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ABSTRACT

The second of a two volume discussion of Kansas' statewide model for inservice and preservice education of teachers of severely handicapped students is the final report. An introductory section provides an overview of the project's goals and discusses the need for teachers of the severely handicapped in Kansas. Objectives for the third year of the project (regional workshops, modified inservice for teachers and paraprofessionals, and preservice for graduate students) are evaluated. The project's organization and coordination with other agencies are depicted in charts and tables. Summary information indicates that 39 teachers completed Master's degree requirements while 85 completed requirements for certification only; 27 modules in the teacher education curriculum were developed; and a procedures model for designing and implementing inservice education was developed. Extended appendixes include content of revised modules, an outline of the procedures manual, and various observation, management, and evaluation forms. (CL)

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FINAL REPORT

A Statewide Inservice Training Model for Teachers of the Severely Handicapped

(#G00 7801689)

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U.S. Department of Education,
Office of Special Education and Rehabiliation Services

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I. INTRODUCTION

This is the final report of a three-year project to provide statewide inservice training to teachers of severely/multiply handicapped individuals. The present report is a review of the objectives that have been met in year three of the Project as well as a summary of accomplishments during the total funding period.

Overview of Objectives

Briefly, the purpose and intent of this special project was to accomplish two major goals:

1.) To design and provide inservice training to teachers of the severely handicapped in the State of Kansas. The inservice training program allowed teachers to pursue staff development activities tailored to their needs, and meet state certification requirements, and/or obtain a Master's level degree in the severely handicapped area. The inservice training model was a joint effort between the Department of Special Education at the University of Kansas and the Kansas State Department of Education. The training program was composed of numerous competency-based modules and was heavily oriented toward practicum experience with severely and multiply handicapped children. It is anticipated that this program will have relevant implications for other states wishing to provide statewide inservice training for teachers of the severely handicapped. To this end, a procedures manual describing the inservice delivery model was prepared for national dissemination; it is included separately from this final report.

2.) To further develop the Kansas University curriculum for preparing teachers of the severely handicapped. Additional instructional modules for educating teachers of severely handicapped students have been developed during this Project and existing ones [1] have been refined. Lecture courses have been closely coordinated with materials in the modules to allow continuation of services following federal withdrawal of funding.

The impact of the Project has resulted in teachers of the severely handicapped in Kansas receiving training leading toward full certification and a general upgrading of skills for certified teachers of severely multiply handicapped students. The primary target population for educational service delivery has conceived as severely and profoundly functionally retarded persons of all ages who might also have been: a) orthopedically disabled, b) perceptually impaired (e.g., deaf-blind), and c) severely emotionally disturbed (e.g., autistic).

Trainees included teachers of the severely handicapped who were new to a college special education program, or teachers already certified in another area of emphasis seeking retraining for additional ,certification in severely handicapped area.

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[1] These existing modules were developed as part of a previously funded personnel preparation project awarded to the University of Kansas during the years 1974-1977 (Grant #OEG-0-74-2766)

Some Considerations for Inservice Training

Teachers of the severely handicapped need to be competent in many areas in addition to academic and pre-academic teaching. They must be able to utilize consultation to implement techniques and procedures traditionally considered the responsibility of physical therapists, occupational therapists, and speech therapists. They must be able to work effectively with parents to implement home training programs, to serve as public relations personnel, and be well-versed in the legal rights of the handicapped. They must know how to task analyze skills, ranging from "rolling over" to "problem solving." These teachers must be able to provide first aid, control hyperactive children, conduct educational evaluations of children for whom no appropriate standardized measurement instruments presently exist, transfer children into and out of wheelchairs and other adapted equipment, teach children to eat, dress, go to the toilet, and many other skills. In essence, teachers of the severely handicapped need to possess many skills that have not traditionally been considered part of education. Therefore, programs designed to prepare effective teachers of severely handicapped children must reach beyond traditional education concepts and expectations.

Although the content of training programs for teachers of severely/profoundly multiply handicapped children requires many changes in, and additions to, traditional training programs, the service delivery systems for that training require equal consideration. Many skilled teachers are needed quickly, and the need is geographically dispersed. The incidence of the population to be served is relatively low in any given area.

Most university and college-based programs have been traditionally geared to providing preservice training. The mandate to fulfill the intent of PL 94-142 involves many teachers who are already in classrooms and who have limited time and/or opportunity to attend traditional preservice programs. However, these teachers represent an important and valuable resource. They may lack many essential skills required to implement appropriate programs for severely handicapped children, but they also have potential strengths. Many of these teachers are settled members of their communities who intend to remain in relatively isolated areas that might have difficulty attracting new graduates. These teachers are often able to organize and utilize community support systems that are essential if handicapped children are to learn how to function in their community. Many of these teachers are already respected members of school programs that will facilitate interaction with nonhandicapped peers and the integration of educational services with other aspects of the school. Further, many of these teachers have already been successful at managing classrooms for both handicapped and nonhandicapped children. They are then able to generalize this experience to working with severely and profoundly handicapped students.

Sontag (1975) called for institutions of higher learning to reconceptualize their role from that of a predominantly preservice delivery system to one that puts equal emphasis upon inservice, staff development, and preservice. These additional emphases are needed because the severely/profoundly handicapped are a low incidence group that is not naturally concentrated in limited geographical areas. Teacher training programs, both inservice and preservice, need to find ways to be effective where children and teachers are not congregated in some artificially contrived center that reflects primarily the convenience of a university's location.

Horner (1977) has noted that traditional inservice training programs are often expensive and inefficient. Funding for inservice training is only a first step. The problem of inefficiency is not as easily resolved. Traditional inservice training has concentrated on providing workshops and one-day inservice training efforts. Tawney (1975) advocated the contingent dispersal of federal funds. In his opinion, funds should not continue to be available for any inservice education program that fails to produce positive changes in teacher behavior. He goes on to suggest that "teacher's skill training can be accelerated if state inservice training support funds are channeled into performance-based programs rather than to one-shot workshops which may or may not change teacher behavior" (p. 93).

This is especially true when the inservice training needs are as rigorous as those required for teachers of the severely and profoundly handicapped. Bijou and Wilcox-Cole (1975) have indicated that training such teachers is not readily accomplished through one-day institutes, short workshops, or presentations by experts. Training procedures must include demonstrations and practice under supervision and guidance, with feedback on performance. Sontag (1975) emphasized the necessity for institutions of higher education to develop better inservice training delivery systems and for this training to take place as close to the teacher's site of employment as possible.

The Statewide Inservice Project involved an alternative to traditional approaches that can be adapted to on-campus programs and a variety of off-campus sites. The primary purpose of the University of Kansas inservice training program for teachers of severely and profoundly handicapped was to train teachers in the rigorous competencies required to teach severely and profoundly handicapped school-age individuals effectively. The program was designed to accomplish this while allowing teachers to continue to work in their own classrooms. To ask teachers to leave their classrooms to study in a distant center would create disruptions in life patterns. Personal hardships might occur, with the result that many teachers could not or would not continue in their profession. It would also result in classrooms being unstaffed and therefore possibly discontinued. This would be in violation of legislation and judicial mandates. Many classrooms might be restaffed by still other inexperienced teachers who would also require training.

Several criteria must be established for an inservice training program to be effective: 1) It must be as rigorous as the existing preservice program (Horner, 1977); 2) It must provide follow-up and feedback on performance; 3) It must be flexible enough to provide training for teachers who have no prior experience with severely and profoundly handicapped; 4) It must provide additional training to personnel who need to keep current on the rapidly expanding information in the field so they can obtain or maintain full certification; and 5) Inservice training must allow teachers to obtain a Master's degree and consequent professional advancement through their participation in the courses while continuing their employment.

The Need for Teachers of the Severely Handicapped in Kansas

The Federal Register (Vol. 42, No. 75; April 19, 1977) explicitly states that preparation of personnel to serve the severely and multiply handicapped is a program priority area. Current and projected needs for teachers of the severely/multiply handicapped in the State of Kansas emphatically reflect this identified priority area (refer to next section).

For several years, Kansas has been fortunate to have Dr. Phyllis Kelly as State Coordinator for the Severely/Multiply Handicapped. This has facilitated cooperation between the State Department of Education and the Special Education Department of the University of Kansas. It has resulted in: (1) establishing a comprehensive state plan that outlines areas of consideration in providing educational services to the severely/multiply handicapped and (2) establishing certification requirements for teachers of the severely/multiply handicapped. The certification requirements (Kansas State Department of Education, 1978) are summarized as follows:

1) The completion of a Bachelor of Science or Arts degree in education or a related field (e.g., Child or Human Development, Early Childhood Education, Physical Therapy, Occupational Therapy, etc.).

2) A minimum of one academic year of successful service (as evidenced by a written recommendation from the supervisor of special education or equivalent individual) in a full-time paid professional position as a special education teacher.

3) General competencies directly related to successful performance as a special education teacher in the classroom to be acquired through at least eight semester hours of coursework and practicum experience in the following areas: a) knowledge and skill in the techniques of teaching exceptional children, b) knowledge and skill in curriculum for exceptional children and the relevance of the curriculum to an exceptional child's functioning in the home and community, c) knowledge and skill in the techniques of extending gains in a child's functioning in the home and community through parents and other members of the community, and d) knowledge of the various roles a special education teacher may assume in special education services provided by the community: Self-contained classroom teacher, itinerant teacher, consulting teacner, homebound teacher, etc.

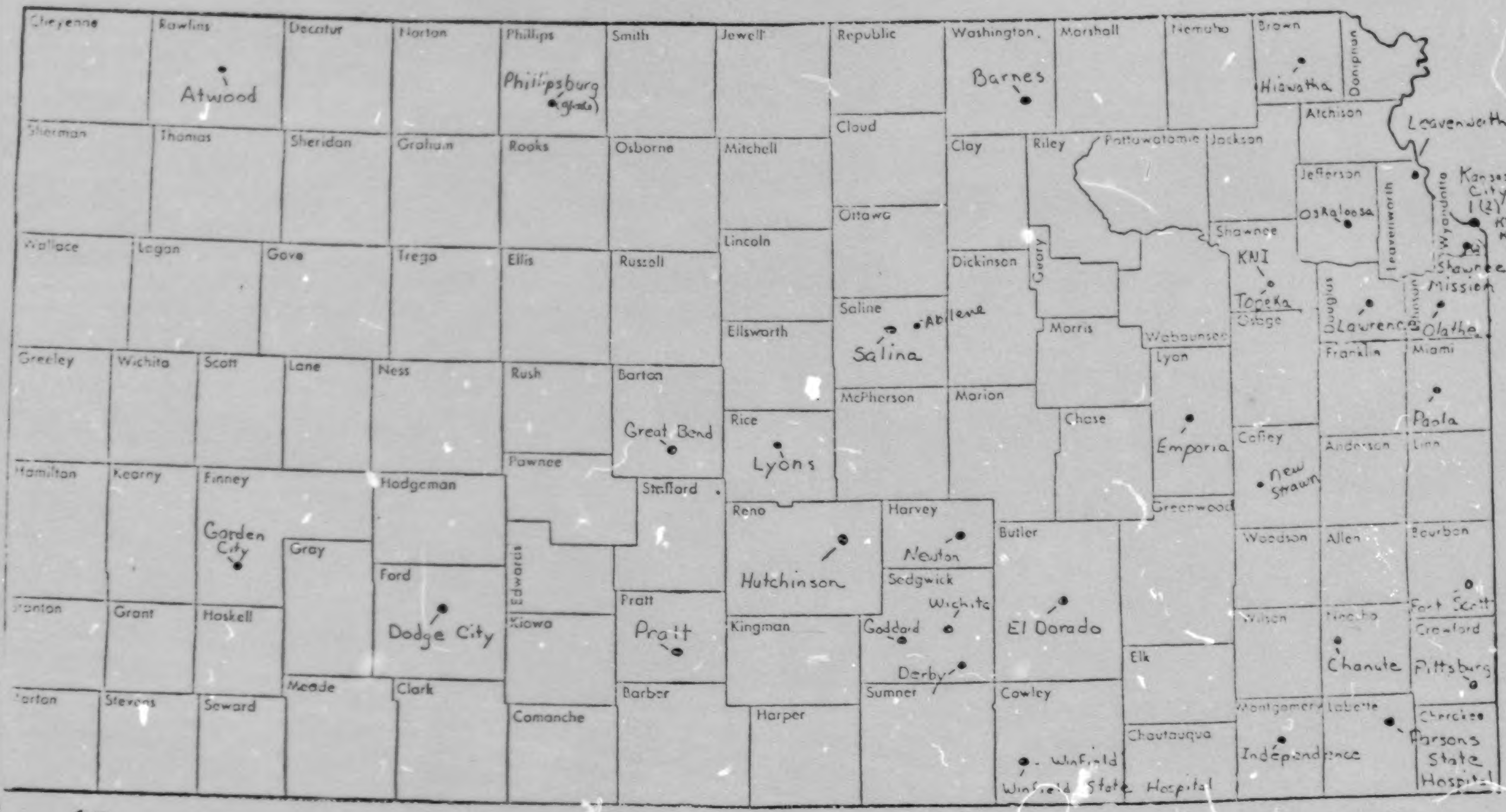
4) At least eight additional semester hours of credit in coursework and practicum experiences which include specific competencies in the following areas: measurement, language development, social development, motor development, and cognitive development.

5) At least ten semester hours of credit in courses and practicum experiences which include competencies in the following areas: a) mental retardation, biological aspects of retarded development and related research, b) classroom organization for classes of multiply/severely handicapped students, c) curriculum development, including methods and materials for multiply/severely handicapped students, and d) vocational training for severely/multiply handicapped students.

6) At least 300 clock hours of supervised teaching of severely/ multiply handicapped students.

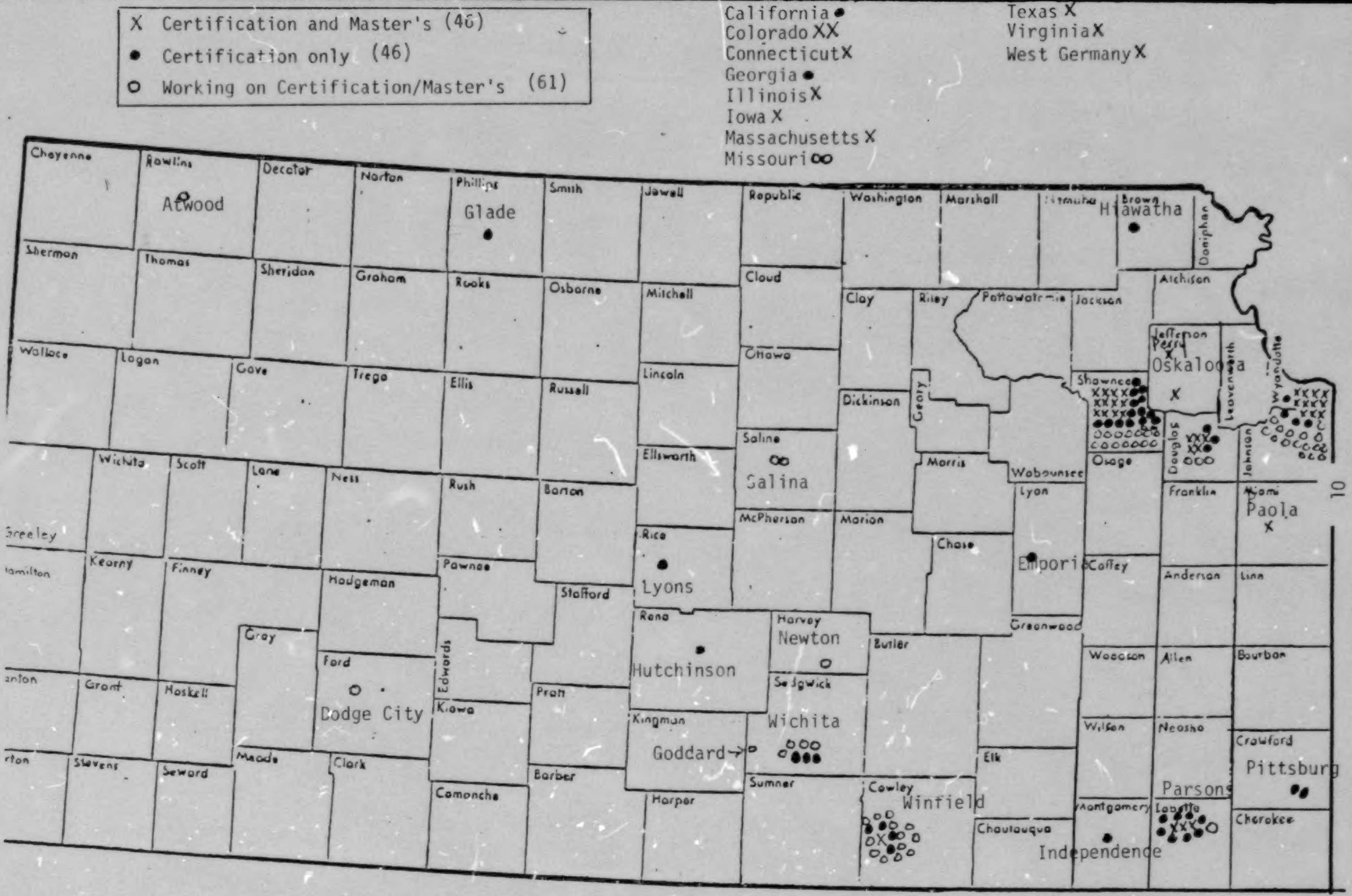
Figures 1 and 2 illustrate several significant and interrelated facts concerning the education of severely/multiply handicapped children in Kansas and the preparation of personnel to provide this education.

1) The rapid growth of classes for severely/multiply handicapped children in the state reflects a genuine effort to meet the mandate to provide educational services to all children as called for in PL 94-142. Recent data compiled by the Kansas State Department of Education show that in 1976 there were 30.6 teachers in classes for the severely/multiply handicapped supported by public school districts. This figure increased to 75.6 in 1977. In 1978, the number of teachers was 64; in 1979 the number increased to 83; and in 1980 the number was maintained at 83. These data do not reflect teachers in institutions who are not affiliated with public school systems. For example, the teachers at Winfield State Hospital are not included in the 1978 and 1979 count, because it was not until 1980 that they became part of a sponsoring school district. Additional data show that 257 severely/multiply handicapped children were served in the public schools in 1976. This figure grew to 398 in 1977. In 1978, this figure decreased slightly to 376, and then to 328 in 1979, and finally a slight increase in 1980 to 350. Figure 1 illustrates the locations of classrooms in Kansas serving severely/multiply handicapped students in 1981.


Atwood
Phillipsburg (grade)
Barnes
Hiawatha
Leavenworth
Kansas City (2)
KSSVH
KSSD (DIB)
Oskaloosa
KNI
Topeka
Shawnee Mission
Lawrence
Olathe
Abilene
Salina
Paola
Emporia
Great Bend
Lyons
New Strawn
Garden City
Hutchinson
Newton
Wichita
Goddard
Derby
El Dorado
Dodge City
Pratt
Fort Scott
Chanute
Pittsburg
Independence
Parsons State Hospital
Winfield
Winfield State Hospital

Locations of SMH/DB Programs in Kansas --- 1981

Figure 1


X Certification and Master's (46)
● Certification only (46)
○ Working on Certification/Master's (61)
California ●
Colorado XX
Connecticut X
Georgia ●
Illinois X
Iowa X
Massachusetts X
Missouri ○○
Texas X
Virginia X
West Germany X
Atwood
Glade
Hiawatha
Oskaloosa
Salina
Paola
Lyons
Emporia
Newton
Hutchinson
Dodge City
Wichita
Goddard
Winfield
Parsons
Pittsburg
Independence
Cheyenne
Rawlins
Decatur
Norton
Phillips
Smith
Jewell
Republic
Washington
Marshall
Nemaha
Brown
Doniphan
Sherman
Thomas
Sheridan
Graham
Rooks
Osborne
Mitchell
Cloud
Clay
Riley
Pottawatomie
Jackson
Atchison
Jefferson
Wallace
Logan
Gove
Trego
Ellis
Russell
Lincoln
Ottawa
Dickinson
Geary
Shawnee
Leavenworth
Wyandotte
Wabaunsee
Douglas
Johnson
Greeley
Wichita
Scott
Lane
Ness
Rush
Barton
Ellsworth
Saline
Morris
Osage
Franklin
Miami
Hamilton
Kearny
Finney
Hodgeman
Pawnee
Rice
McPherson
Marion
Chase
Lyon
Coffey
Anderson
Linn
Stafford
Reno
Harvey
Butler
Greenwood
Woodson
Allen
Bourbon
Gray
Ford
Edwards
Stanton
Grant
Haskell
Kiowa
Pratt
Kingman
Sedgwick
Wilson
Neosho
Crawford
Morton
Stevens
Seward
Meade
Clark
Comanche
Barber
Harper
Sumner
Cowley
Elk
Chautauqua
Montgomery
Labette
Cherokee

Teachers Working Toward Certification and/or Master's Degree

Figure 2

2) The certification requirements outlined by the Kansas State Department of Education reflect an attempt to place teachers in these classes who can provide quality educational services. Figure 2 illustrates the number of teachers served by the Project, by city. It also denotes the type of degree earned by each student. The separate states listed at the top of the figure represent teachers trained by the Project who have relocated to other areas of the country.

In accordance with PL 94-142, educating children in the least restrictive alternative (LRA) has been of concern to Project staff. Although the Project had no real control over student placement, the staff encouraged the LRA concept in several ways:

1) Through the content of informational modules,
2) Through specific written assignments in the practica,
3) By assisting inservice trainees who were interested in pursuing jobs in public school settings,
4) By placing preservice students in public school classrooms.

Figure 3 reflects the educational settings of practicum students throughout the three years of the Project--that is, number of classrooms located in integrated public schools, special day schools, and finally, institutions. It should be noted that as practicum settings in residential facilities decreased, settings in the integrated public school have increased.

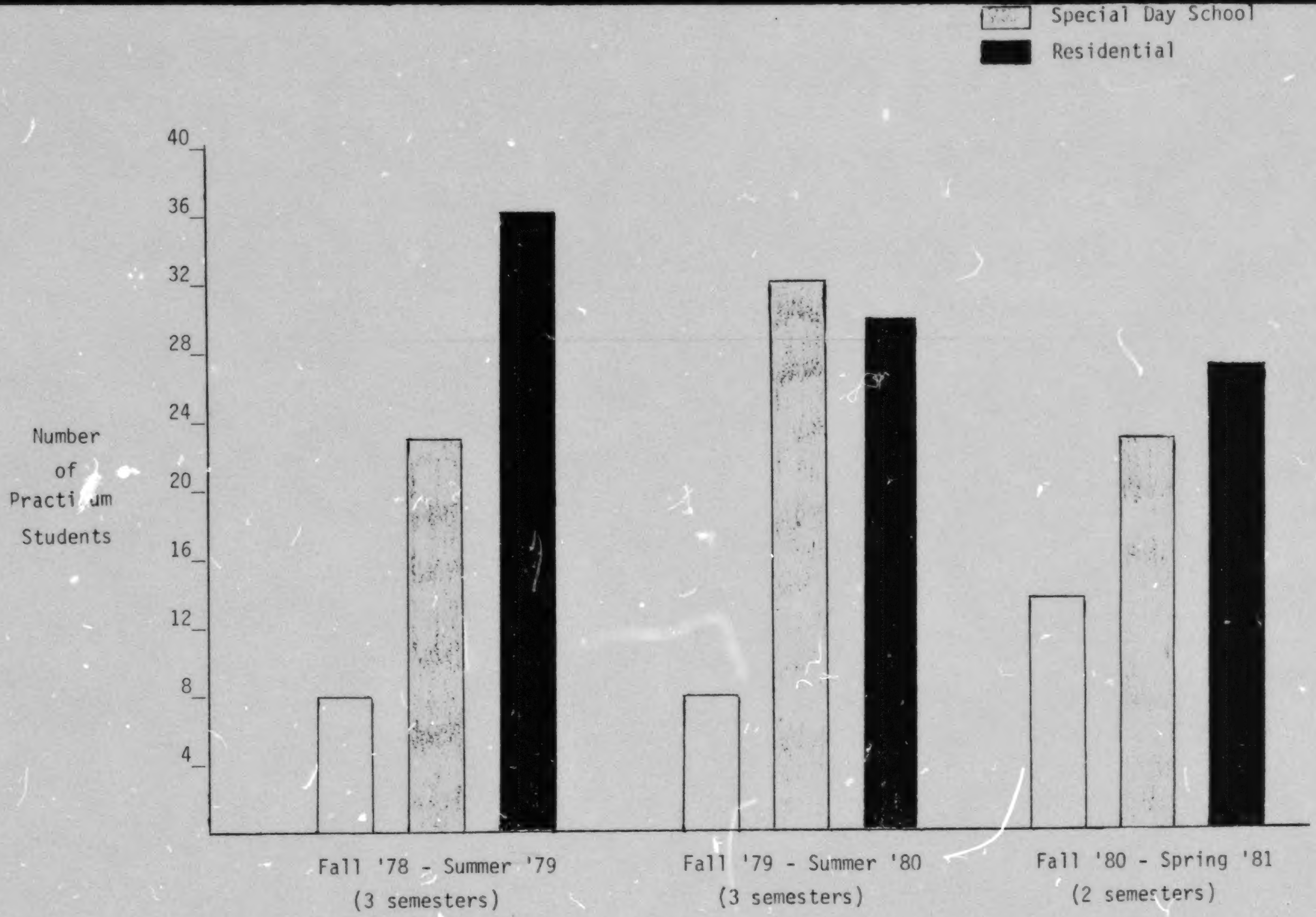


Figure 3

Educational Settings of Practicum Students

II. MEETING THE OBJECTIVES FOR YEAR THREE

Table 1 summarizes the objectives set forth by Project staff in the continuation proposal for the third year of the Project. The Project at this time has met or is in the process of completing the following objectives.

1. Inservice Training Component

Inservice trainers are those teachers who are employed full-time in their own classroom but require an appropriate course of instruction to meet state certification requirements. Inservice trainees' classrooms are located outside of a 60-mile radius of the University of Kansas campus in Lawrence. Modified inservice trainees are also employed full-time in their own classroom. However, they are located within a 60-mile radius of the Lawrence campus. Preservice trainees are not employed full-time in a classroom but are full-time graduate students. These trainees are placed by the Project in designated classrooms for their practicum experiences. These teachers can be working towards a Master's degree as well as certification.

1.1 Continue to serve inservice teachers. Enrollment of students in the Project has continued to cover all areas of Kansas. Figure 4 represents the geographic locations of all students (Inservice, Modified Inservice, and Preservice) enrolled in practicum courses in fall 1980/ Spring 1981. Figure 5 is a summary of enrollment in the Project, from Summer 1977 to Spring 1981. This chart is broken down into preservice, inservice (which

Table 1

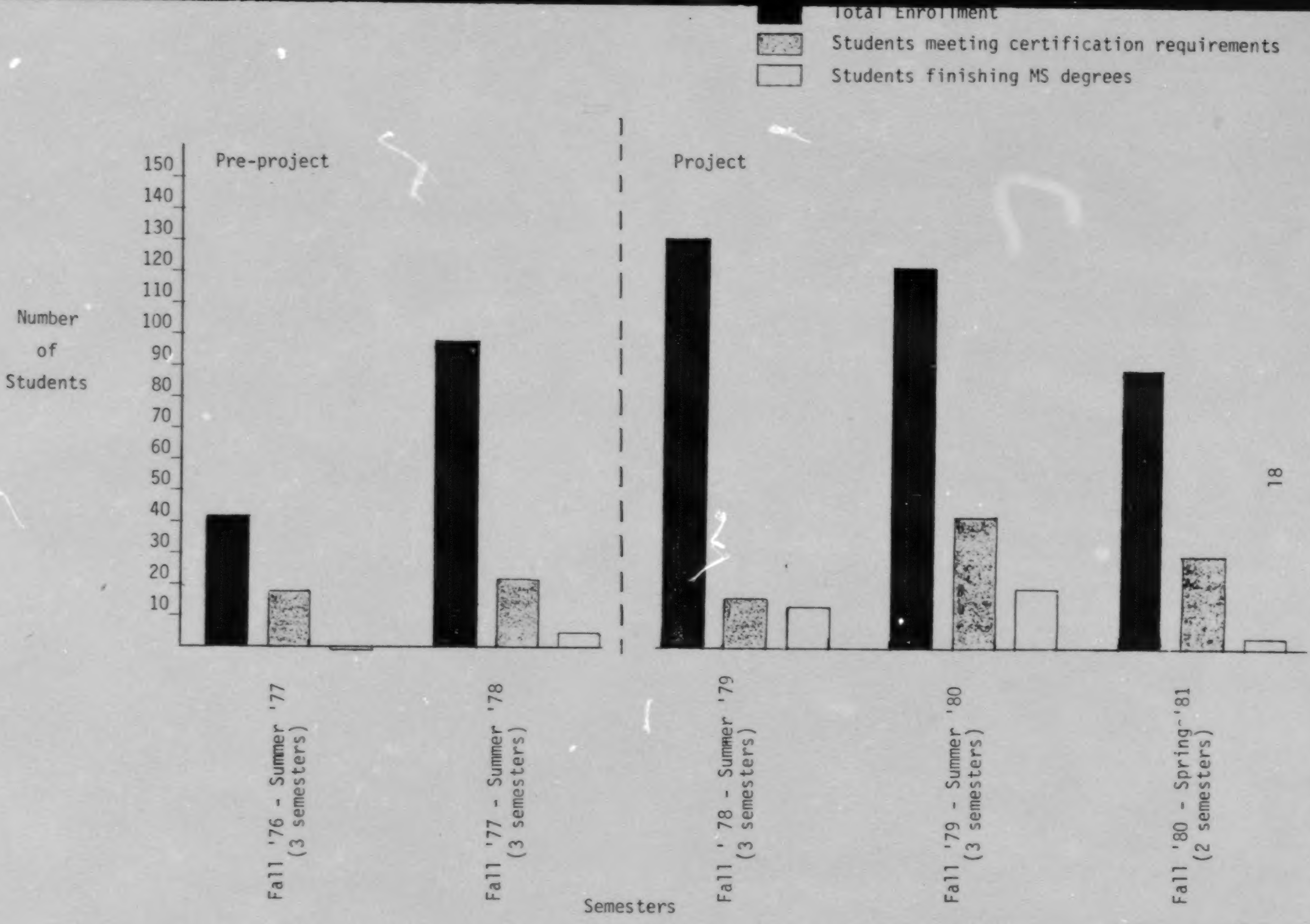
Timetable of Quarterly Objectives for Year Three

Months	Inservice Training	Modified Inservice	Preservice	Other
0-3 months	1.1 Continue to serve inservice teachers. 1.2 Arrange at least one inservice workshop in the eastern portion of the state. 1.3 Offer three courses (9 cr. hours) in summer curriculum.	2.1 Continue to identify and recruit students for modified inservice. 2.2 Offer five courses (16 cr. cr. hours) in summer curriculum.	3.1 Continue to identify and recruit students for preservice Master's program. 3.2 Continue to identify and recruit students for preservice Doctoral program. 3.3 Offer five courses (16 cr. hours) in summer curriculum	4.1 Revise procedures manual. 4.2 Present one workshop to professionals other than teachers. 4.3 Begin procedures for commercial dissemination of training modules if publishers are interested.
3-6 months	1.4 Offer four courses (12 cr. hours) in fall curriculum. 1.5 Coordinate transition with Parsons and Winfield State Hospitals.	2.3 Offer six courses (19 cr. hours) in fall curriculum. 2.4 (a)Revise modules 2, 3, 9 and 12. 2.4 (b)Additional module developed.	3.4 Offer six courses (19 cr. hours) in fall curriculum. 3.5 Identify and contact graduates of program who could serve as practicum supervisors.	
6-9 months	1.6 Offer three courses (10 cr. hours) in spring curriculum. 1.7 Arrange at least one inservice workshop in the southern portion of the state.	2.5 Offer four courses (13 cr. hours) in spring curriculum. 2.6 Revise any additional modules that need it. 2.7 Coordinate with SMH Doctoral program to obtain supervisors for practicum.	3.6 Offer four courses (13 cr. hours) in spring curriculum	

includes modified inservice), and other. The "other" category implies that the student is in a different area of emphasis in special education but is enrolled in a Project class as an elective.

Figure 6 is another summary presentation of the Project showing the numbers of students meeting certification and/or Master's degree requirements.

1.2 Arrange and present workshops. In conjunction with the State Department of Education, the Project arranged and coordinated three regional workshops in 1980-81. Figure 7 represents the regions of the state as defined by the State Department of Special Education. The shaded areas are those counties that were coordinated by the Project staff. Prior to each workshop, the State Department of Special Education contacted all school districts and institutions in the designated region that employed teachers of the severely/multiply handicapped and requested that these persons be allowed to attend the workshops. Most districts were able to send either the teacher and/or a representative (usually an occupational therapist, a supervisor, or a psychologist) to these meetings. Many districts and institutions also sent paraprofessionals.



Number of Students Meeting Certification and/or Master's Degree Requirements: Figure 6

Regions of Kansas as defined by the State Department of Special Education. The shaded areas are those regions that were coordinated by the Project staff.

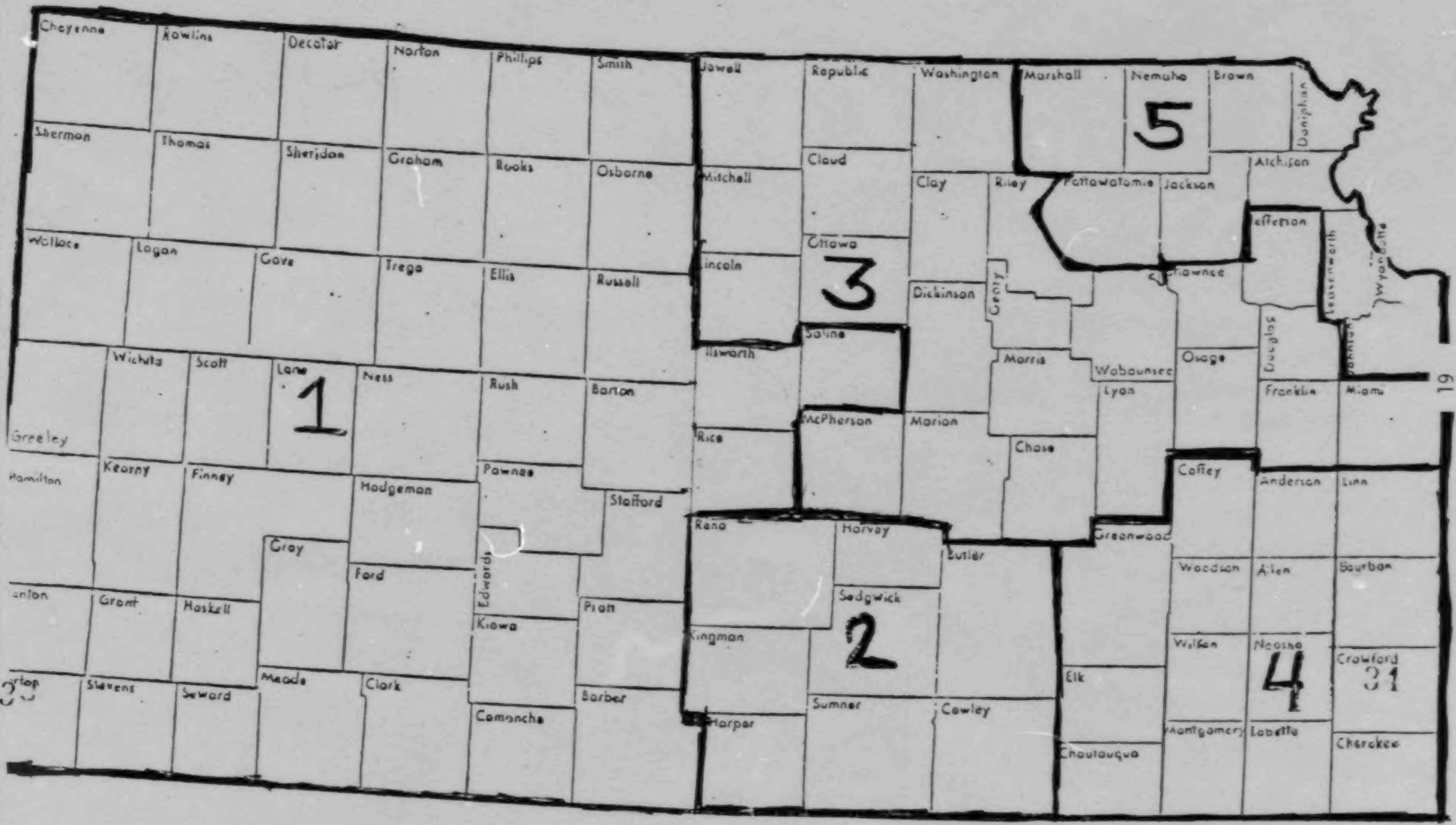

Cheyenne
Rawlins
Decatur
Norton
Phillips
Smith
Jewell
Republic
Washington
Marshall
Nemaha
Brown
Doniphan
5
Sherman
Thomas
Sheridan
Graham
Rooks
Osborne
Mitchell
Cloud
Clay
Riley
Pottawatomie
Jackson
Atchison
Jefferson
Leavenworth
Wyandotte
Wallace
Logan
Gove
Trego
Ellis
Russell
Lincoln
Ottawa
3
Dickinson
Geary
Shawnee
Saline
Ellsworth
Morris
Wabaunsee
Osage
Douglas
Johnson
Greeley
Wichita
Scott
Lane
1
Ness
Rush
Barton
Rice
McPherson
Marion
Chase
Lyon
Franklin
Miami
Hamilton
Kearny
Finney
Hodgeman
Pawnee
Stafford
Coffey
Anderson
Linn
Gray
Ford
Edwards
Reno
Harvey
Butler
Greenwood
Woodson
Allen
Bourbon
Stanton
Grant
Haskell
Kiowa
Pratt
Kingman
Sedgwick
2
Wilson
Neosho
4
Crawford
31
Morton
33
Stevens
Seward
Meade
Clark
Comanche
Barber
Harper
Sumner
Cowley
Elk
Chautauqua
Montgomery
Labette
Cherokee

Figure 7

Project staff planned and coordinated an all-day workshop in Shawnee Mission for Region 5 on March 13, 1981. This workshop covered three main topics: Self-advocacy/independent living; vocational tasks, and functional communication development. Speakers for this region included: two teachers (Chris Curry and Eileen Luddy); staff members of the Kansas UAF (Howard Moses and Jeff Woodyard); and Project staff of the Comprehensive Communication Curriculum (CCC) Grant, located at Kansas Neurological Institute (Sue Ann Carpenter, Maura K. Hall, Diane Klein, Deb Latham, Stephan Paul Myers, Lois Waldo, and Susan Vanost Wulz).

The Region 1 workshop, planned and coordinated by Project staff was held in Great Bend, Kansas on April 9, 1981. The topics of this workshop were similar to the Region 5 workshop. The CCC staff presented for one-half of the workshop session, and Eileen Luddy, a teacher, covered the area of vocational training of the severely handicapped.

The third all-day workshop coordinated by the Project covered Region III. It was held on-campus in Lawrence and covered two main topics: 1) fluency and rate in student performance and 2) vocational education. This workshop featured Dr. Ogden R. Lindsley and Dr. Gary Clark, both from the School of Education at the University of Kansas.

Project staff have also presented a number of workshops during the Fall 80/Spring 81 semesters. Table 2 represents staff participation in these workshops.

Additionally, technical assistance to specific classroom teachers was provided as follows:

1. Sept. 8, 1980 in Hutchinson, Kansas. Topics included:
    a. Setting up a classroom
    b. IEP development
    c. Positioning techniques
    d. Measurement procedures
    e. Instructional program development
2. Sept. 29, 1980, in Salina Kansas. Technical assistance was offered for two students in an SMH classroom. Areas covered included:
    1. developing objectives
    2. measurement techniques
    3. teaching procedures

1.3 Offer Summer 1980 courses. During Summer 1980, the following courses were offered for 12 credit hours to inservice students: SPED 726 (Modules 1-5); SPED 772 (Basic Practicum); SPED 839 (Modules 6-8); and SPED 875 (Intermediate Practicum). Enrollment figures for these courses were: 7, 2, 10, and 1, respectively..

Liaison personnel at Parsons State Hospital, Parsons

Table 2

Project Staff Presentations During the Fall 80/Spring 81 Semesters

Date	Topic	Faculty	Audience
8/19/80	Individual curriculum sequencing model and group programming	Idaho state school for deaf/blind	Teachers, paraprofessionals, ancillary personnel
10/9/80	Paraprofessionals in the SMH classroom	Northville public schools, Detroit	paraprofessionals
11/10/80	Group instruction	University of Kansas, Lawrence	University undergraduate students
11/13/80	Teacher rap: Feedback from trainees in the inservice project	State Department of Education, Topeka	Trainees in the project
11/14/80	Social interaction skills: A systematic approach	State Department of Education, Topeka	teachers, paraprofessionals, ancillary personnel

offered SPED 839, 860, 772, 975. The total enrollment for these four courses was six inservice students.

1.4 Offer Fall 1980 courses: The following courses were offered in the Fall 1980 semester to inservice students:

SPED 726	Module 1	Right to Education
	Module 2	Behavior Approach to Education
	Module 3	Programming Engaging Environments
	Module 4	Programming for Normalization
	Module 5	Assessment Scales
SPED 839	Module 6	Writing Instructional Programs
	Module 7	Measuring Operant Behavior
	Module 8	Evaluation of Operant Behavior
SPED 772	Module 9	Basic Practicum
SPED 760	Module 10	Strengthening Operant Behavior
	Module 11	Weakening Operant Behavior
	Module 12	Discrimination and Stimulus Control
	Module 13	Programming for the Physically Handicapped
	Module 14a	Programming Prosthetic Enviornments
	Module 14b	Medical Aspects in the Classroom
SPED 875	Module 15	Intermediate Practicum

Enrollment figures of inservice students for these courses were: SPED 726=4; SPED 839=6; SPED 772=2; SPED 760=6; and SPED 875=12. Liaison personnel at Parsons State Hospital, Parsons, offered SPED 772, 760 and 726. The total enrollment for these three courses was three inservice students.

1.4 Offer Fall 1980 courses: The following courses were offered in the Fall 1980 semester to inservice students:

SPED 726	Module 1	Right to Education
	Module 2	Behavior Approach to Education
	Module 3	Programming Engaging Environments
	Module 4	Programming for Normalization
	Module 5	Assessment Scales
SPED 839	Module 6	Writing Instructional Programs
	Module 7	Measuring Operant Behavior
	Module 8	Evaluation of Operant Behavior
SPED 772	Module 9	Basic Practicum
SPED 760	Module 10	Strengthening Operant Behavior
	Module 11	Weakening Operant Behavior
	Module 12	Discrimination and Stimulus Control
	Module 13	Programming for the Physically Handicapped
	Module 14a	Programming Prosthetic Enviornments
	Module 14b	Medical Aspects in the Classroom
SPED 875	Module 15	Intermediate Practicum

Enrollment figures of inservice students for these courses were: SPED 726=4; SPED 839=6; SPED 772=2; SPED 760=6; and SPED 875=12. Liaison personnel at Parsons State Hospital, Parsons, offered SPED 772, 760 and 726. The total enrollment for these three courses was three inservice students.

Revisions based on fall courses. Item analyses were made on exams 1-14, and revisions were made on these questions missed by one-half the students or where more than one-third of the students received less than half credit.

1.5 Coordinate transition with Parsons and Winfield State Hospitals. Currently, attempts are being made to continue services at Winfield State Hospital and Training Center. These services would be a coordination between the local school district and the University of Kansas. Presently, no special courses are being planned for the next school year at Parsons State Hospital. The availability and status of certified teachers will be reexamined within one year, with the possibility of continuing coursework through faculty members presently located in Parsons.

1.6 Offer Spring 1981 courses. The following courses were offered in the Spring 1981 semester to inservice students: SPED 839 (Modules 5-8); SPED 760 (Modules 10-14); SPED 860 (Modules 16-24); SPED 875 (Intermediate Practicum); SPED 975 (Advanced Practicum). Enrollment figures for these courses were: 7, 3, 9, 1, 12, respectively.

Liaison personnel at Parsons State Hospital, Parsons, offered: SPED 839, 860, 875, and 975. The total enrollment for these four courses was four inservice students.

A new module, Medical Aspects in the Classroom, was added to SPED 760. Because this module seemed to be related to Module 14, Programming Prosthetic Environments, it was labeled Module 14b; the original Module 14 was than relabeled 14a. The information in this module covered the following topics: general and emergency classroom procedures; the deaf-blind student; the abused child; teacher-professional interrelationships; and mental retardation syndromes. (See Appendix A for a copy of the module).

1.7 See Section 1.2

2. Modified Inservice.

Modified inservice is the second category of persons served by the Project. These trainees were already employed in an SMH classroom, either as a teacher or as a paraprofessional. The difference between this category and the inservice category is the distance of their practicum site from the Lawrence campus. The modified inservice training sites were located within a 60-mile radius of Lawrence. These students took a combination of modular-based courses and on-campus, lecture-based courses. SPED 726: Introduction to Education of Exceptional Children: SMH (Modules 1-5) was offered only through modular format. SPED 839: Management Principles and Assessment Procedures for SMH (Modules 6-8) was offered in modular format or through a lecture course. SPED

760 and SPED 860 were offered only in lecture format to these teachers. Project personnel supervised the practica for these students in their respective classrooms and were also available as support and resource personnel. Some of these students were pursuing certification only; others were working towards completion of all the Master's degree requirements.

2.1 Recruitment of students: (Same as 1.1)

2.2 Offer Summer 1980 courses: The following courses (16 credit hours) were offered to modified inservice students during Summer 1980:

SPED 726	Module 1	Right to Education
	Module 2	Behavioral Approach to Education
	Module 3	Programming Engaging Environments
	Module 4	Programming for Normalization
	Module 5	Assessment Scales
SPED 839	Module 6	Writing Instructional Programs
	Module 7	Measuring Operant Behavior
	Module 8	Evaluation of Operant Behavior
SPED 772	Module 9	Basic Practicum
SPED 875	Module 15	Intermediate Practicum
SPED 975	Module 25	Advanced Practicum

Enrollment figures for modified inservice students were: SPED 726=3; SPED 839=3; SPED 772=4; SPED 875=2; SPED 975=3.

2.3 Offer Fall 1980 courses: The following courses (19 credit hours) were offered in the Fall 1980 semester to modified inservice students:

SPED 726	Modules 1-5
SPED 839	Modules 6-9
SPED 760	Lecture Format
SPED 772	Module 9, Basic Practicum
SPED 875	Module 15, Intermediate Practicum
SPED 975	Module 25, Advanced Practicum

Total enrollment figures for all inservice students were: 2, 1, 10, 2, 8, and 2, respectively.

2.4 Revise Modules.

A. Three sources indicated need for revisions in certain modules: 1) feedback given by students in module evaluations, 2) data compiled in an item analysis of module exams, and 3) new information on the subject made available in the literature. Revisions were made in modules 2, 3, 8 and 12 as a result of these considerations. Most of the changes in these modules consisted of updating articles or narratives.

B. A new module, Medical Aspects in the Classroom, was written by Project personnel and a student in the doctoral program. This module, 14b, to follow module 14, Programming Adaptive Environments, became a requirement for SPED 760, Education of Exceptional Children and Youth I. It was developed to address those needs of teachers in the SMH classroom who must be familiar with and understand how medical aspects relate to a classroom for the severely and multiply handicapped (See Appendix A.)

2.5 Offer Spring 1981 courses. The following courses were offered in the Spring 1981 semester to modified inservice students:

SPED 839	Module 6-8 or Lecture Format
SPED 875	Intermediate Practicum (Module 15)
SPED 860	Lecture Format
SPED 975	Advanced Practicum (Module 25)

Enrollment figures for modified inservice students were as follows: 3, 0, 10, and 8, respectively.

2.6 Revise additional practica. A final revision was done on the Basic, Intermediate, and Advanced Practica in Fall 1980 and Spring 1981. These practica revisions were seen as necessary for several reasons:

1) Some supervisors and trainees felt that some of the criteria and assignments were too ambiguous;

2) The Project staff felt that the Advanced Practicum should better reflect the competency of total classroom management; at this stage, the trainee should be responsible for management of all students in the classroom, not just a selected few;

3) The Project staff felt that the Advanced Practicum should more clearly reflect an integration of the skills and competencies acquired in the Basic and Intermediate practica;

4) New information and teaching techniques developed in the field needed to be integrated into the curriculum.

Figures 8, 9, and 10 are flow charts of the final revision of each practica. This format shows the integration of the various competencies within each level of practicum. A goal of a practicum is to coordinate individual and isolated theories and competencies into a meaningful, working whole. Copies of revised practica are found in Appendix A.

2.7 Coordinate with SMH doctoral program to obtain supervisors for practicum. Coordination with the doctoral program was done in Fall 1980 and Spring 1981 semesters. Three doctoral students supervised eight trainees in the fall semester and four trainees in the spring semester.

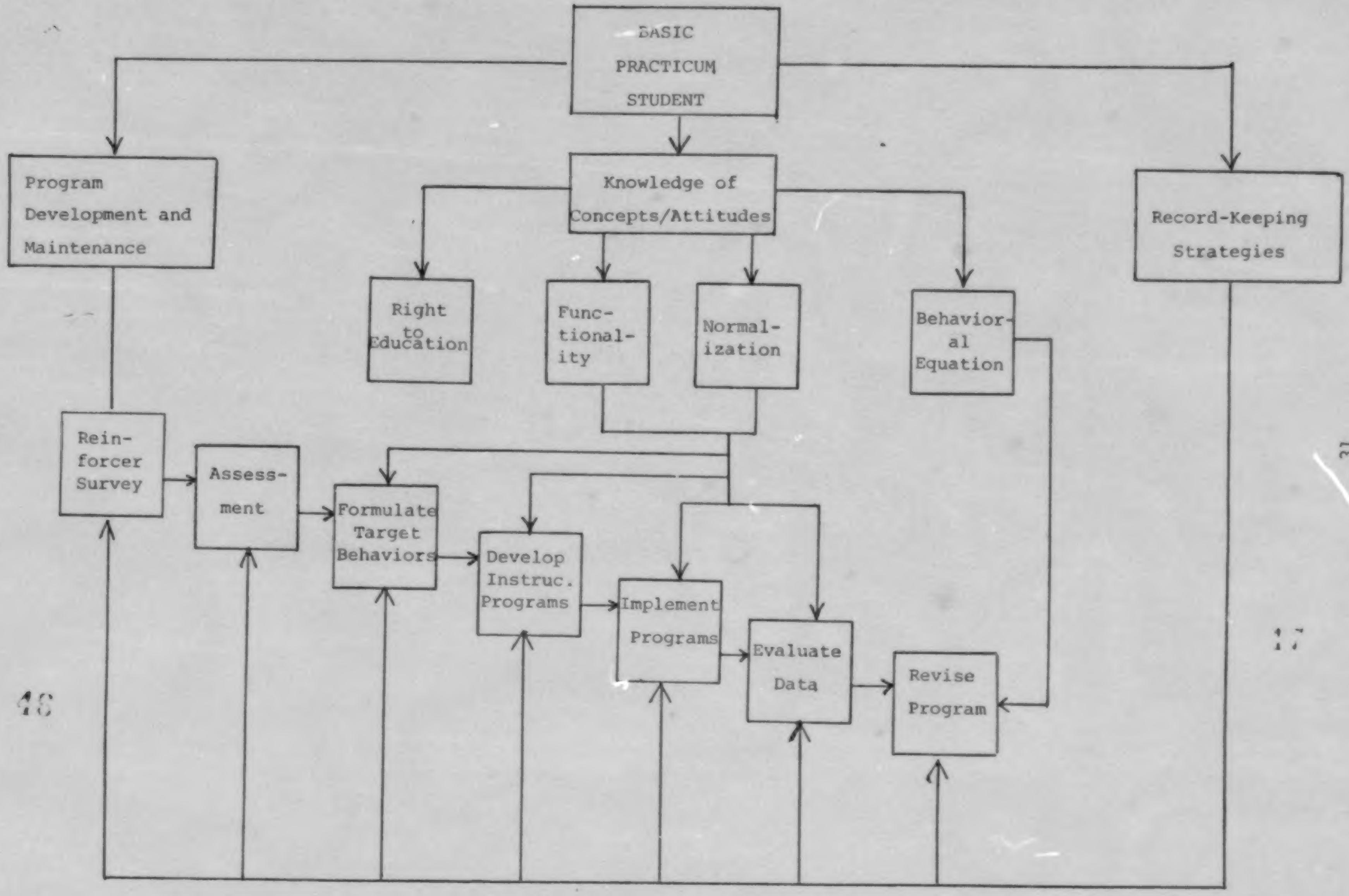

BASIC PRACTICUM STUDENT
Program Development and Maintenance
Knowledge of Concepts/Attitudes
Record-Keeping Strategies
Right to Education
Func-tional-ity
Normal-ization
Behavior-al Equation
Rein-forcer Survey
Assess-ment
Formulate Target Behaviors
Develop Instruc. Programs
Implement Programs
Evaluate Data
Revise Program

Figure 8

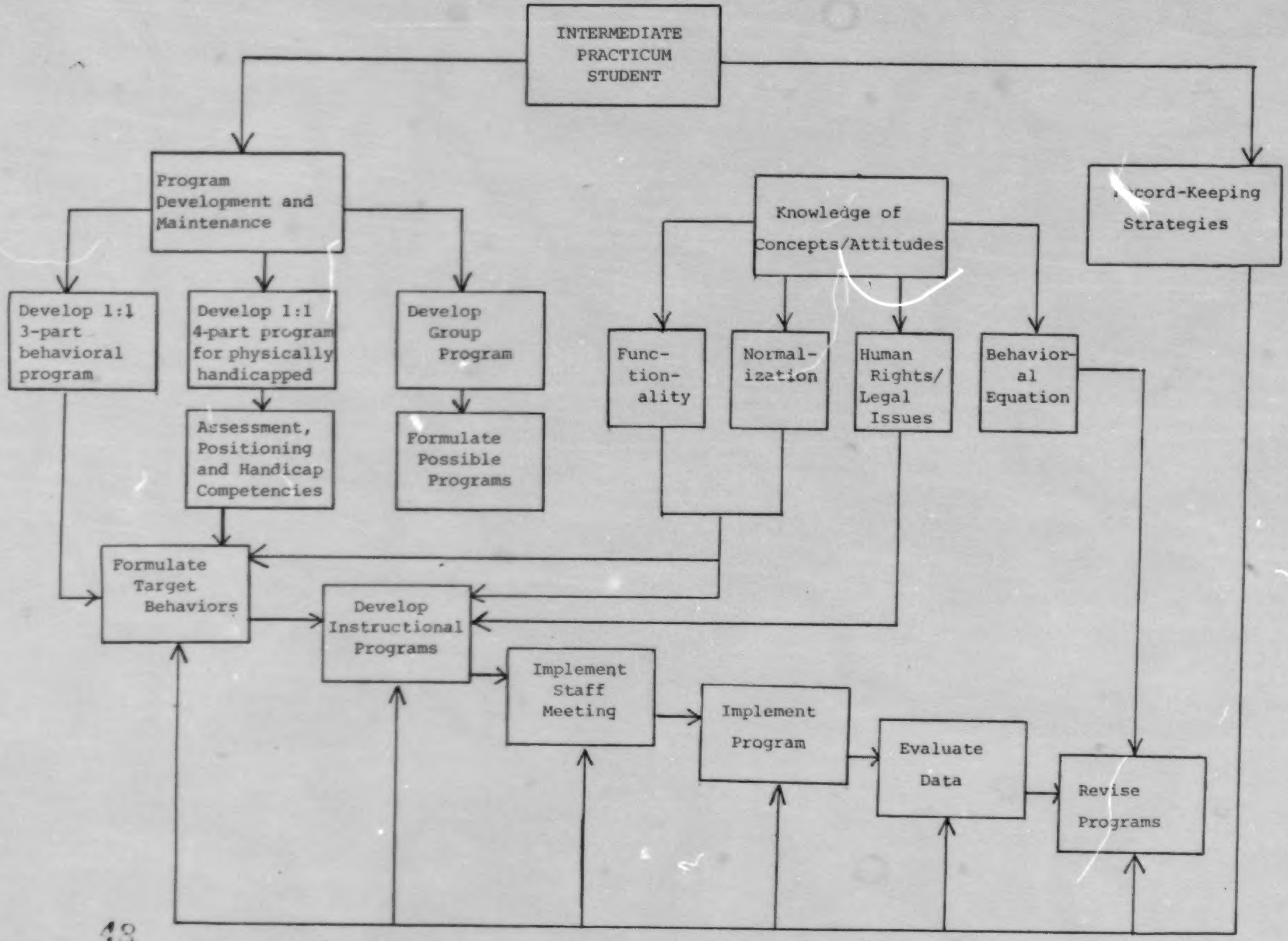
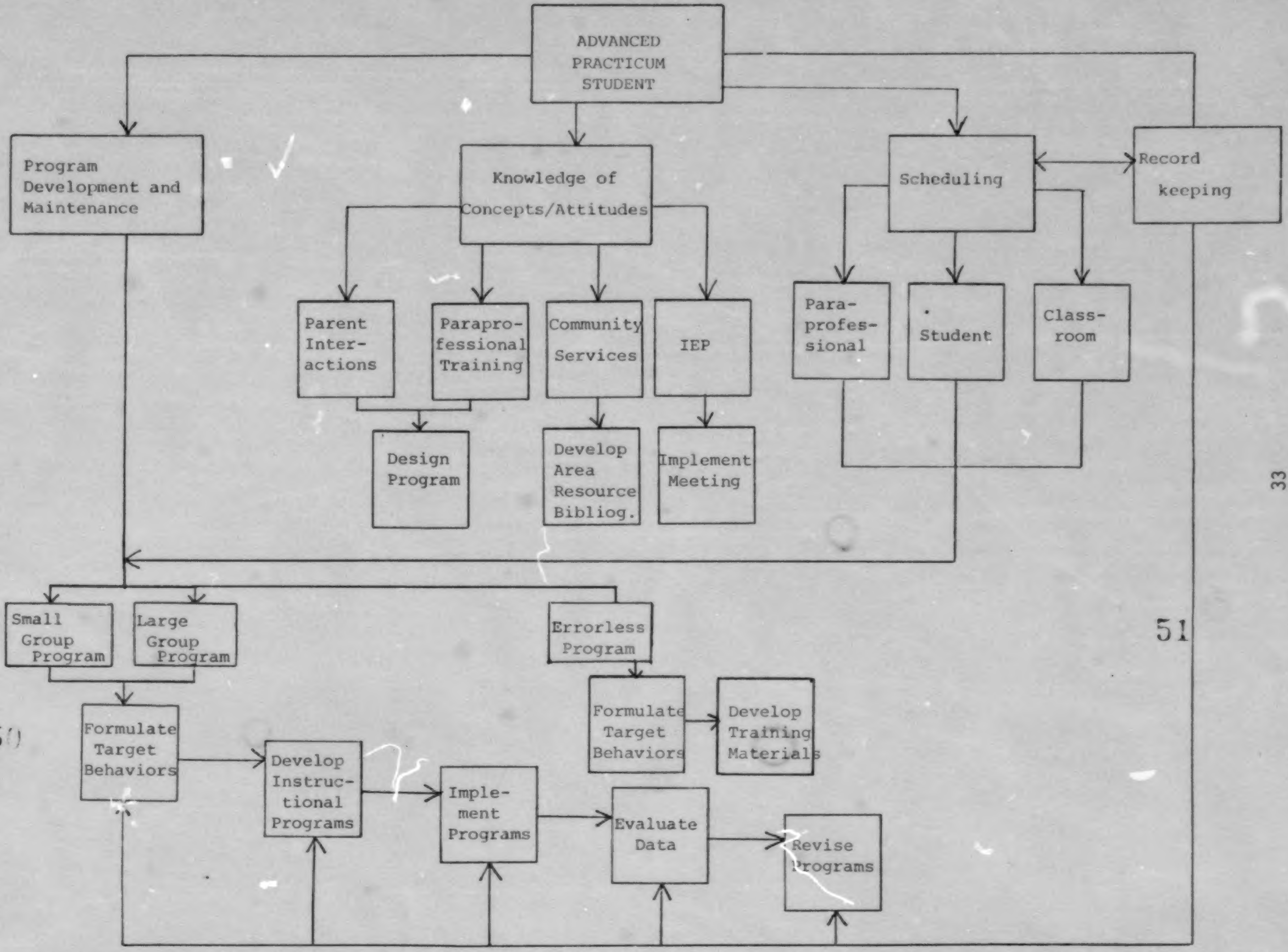

INTERMEDIATE PRACTICUM STUDENT
Program Development and Maintenance
Knowledge of Concepts/Attitudes
Record-Keeping Strategies
Develop 1:1 3-part behavioral program
Develop 1:1 4-part program for physically handicapped
Develop Group Program
Func-tion-ality
Normal-ization
Human Rights/ Legal Issues
Behavior-al Equation
Assessment, Positioning and Handicap Competencies
Formulate Possible Programs
Formulate Target Behaviors
Develop Instructional Programs
Implement Staff Meeting
Implement Program
Evaluate Data
Revise Programs

Figure 9


ADVANCED PRACTICUM STUDENT
Program Development and Maintenance
Knowledge of Concepts/Attitudes
Scheduling
Record keeping
Parent Inter-actions
Parapro-fessional Training
Community Services
IEP
Para-profes-sional
Student
Class-room
Design Program
Develop Area Resource Bibliog.
Implement Meeting
Small Group Program
Large Group Program
Errorless Program
Formulate Target Behaviors
Develop Training Materials
Formulate Target Behaviors
Develop Instruc-tional Programs
Imple-ment Programs
Evaluate Data
Revise Programs

3. Preservice Component

The preservice component continued to prepare teachers for classrooms that served severely/multiply handicapped individuals. This component served those student teachers who were not currently employed by a school district, institution, cooperative, or private school. This component led to Master's degree in education or a Doctorate in Philosophy or Education.

3.1 Continue to identify and recruit Master's level students. There was a total of 10 students enrolled in the program under the preservice component. Enrollments for each semester were as follows: Summer 1980=1; Fall 1980=8; Spring 1981=9.

3.2 Recruit students for doctoral program. There are currently 12 students enrolled in the preservice doctoral program. The one new doctoral student this year began in the Fall, 1980.

3.3 Offer Summer 1980 courses. Students in the preservice component were offered the same courses as those outlined in the modified inservice component. Additional courses were offered to students in the doctoral program. Practicum sites were identified in the Lawrence-Topeka-Kansas City area for the summer, fall and spring. In all cases, these classrooms were taught by teachers who had completed at least two practica and all of the informational courses in the SMH curriculum. All teachers held full or provisional Kansas certification. Following is a description of those sites that were available for preservice student placement (although not all sites were used):

Site: Sweeney Elementary School, Kansas City, MO

Responsible Agency: Kansas City, Missouri School District

Number of Children: 4

Ages: 2-5

Description of Population: Severely multiply handicapped preschoolers. Three students non ambulatory and nonverbal; 1 students walks and is developing speech.

Education Emphasis: Self-help training; communication development; early cognitive skills and motor development.

Special Training Opportunities: Participation in a transdisciplinary classroom setting; experiences in a preschool; parent involvement experiences and curriculum emphasis on cognitive skill development.

Site: Topeka Education Center, Topeka, KS

Responsible Agency: 501 School District, Topeka. These were,two classrooms in a demonstration program for severely handicapped, funded by the Office of Education (#OEG-1621).

Head Teacher: Ed Helmstetter

Total Number of Children: 12 (from homes and state institutions)

Ages: 13-21

Description of Population: Severely retarded with motor impairments; nonverbal; nonambulatory or partially ambulatory.

Educational Emphasis: Sensory/motor development; communication training; social development; preacademic, and prevocational/vocational training.

Special Training Opportunities: A highly data-based program; intense training in orientation and motor development; community integration training.

Site: Kansas University Medical Center

Responsible Agency: The University of Kansas Department of Special Education

Head Teacher: Cindy Jones

Number of Children: 8

Ages: up to 6 years

Description of Population: Preschool children with severe/profound developmental retardation and at least one additional handicap. Additional handicapping conditions include severe visual and auditory and nonverbal.

Educational Emphasis: Sensory/motor development; self-help training; communication training (oral and nonoral); reduction of self-stimulation and self-injurious behavior.

Special Training Opportunities: Participation in a transdisciplinary classroom setting, including physical therapists, occupational therapists, speech therapists, nurses, and psychologists; experiences in a data-based early intervention program; active parent training program for children in the classes.

Site: Sheldon School, Topeka, KS

Responsible Agency: USD 501, Topeka

Head Teacher: Ed Helmstetter

Number of Children: 14

Ages: 6-13

Description of Population: Severely/profoundly retarded and severely disturbed; two are nonaubulatory; seven children are nonverbal.

Eduational Emphasis: Self-help training; communication training; social training; behavior control problems and motor development.

Special Training Opportunities: A heavy emphasis on communication development and social development; data-based; extensive use of procedures to reduce inappropriate behavior.

Site: Cordley School, Lawrence, KS

Responsible Agency: Lawrence Public Schools, USD 497

Number of Children: 7

Ages: 7-17

Description of Population: Severely and profoundly retarded students. Characteristics include autistic behavior, nonambulatory and nonverbal or speech deficient. (A heterogenous population typical of SMH classes in small communities.)

Educational Emphasis: Self-help training; communication training; behavior control programs; preacademic and prevocational training.

Special Training Opportunities: Experience in working with a "typical SMH classroom: in a public school setting; writing IEPS for public schools; data-based.

3.4 Offer Fall 1980 courses. The students in the preservice component were offered the same courses as those outlined in the modified inservice component. Additional courses were offered to students in the doctoral program.

3.5 Identify and contact graduates of program who could serve as practicum supervisors (see 3.3 site descriptions).

3.6 Offer Spring 1981 courses. The same courses outlined in the modified inservice component were offered to preservice students.

4. Other Objectives

4.1 Procedures Manual. The Procedures Manual describing how to design and implement an inservice and modified inservice program has been completed. An outline of the contents of the Procedures Manual is in Appendix B.

It was decided to pursue commercial publication of the Procedures Manual. Project staff felt that the information involved would be of great assistance to those individuals beginning, as well as those already involved in an inservice program. The information in the Procedures Manual is applicable across populations of students, i.e., the content would be appropriate to an inservice program for teachers of the SMH, TMR, and LD.

4.2 Present workshops. In the past several semesters, a series of workshops have been presented to pediatric residents at the University of Kansas Medical Center. The main goal of these workshops has been to expand the training that pediatric residents receive in relation to the handicapped and their families. Table 3 is a list of the objectives for the workshop series.

4.3 & 4.4 Commercial dissemination of training modules. It was finally decided not to pursue commercial publication of the teacher training modules. Considerations that went into the decision were as follows:

1) The bulk of a total set of training modules might interfere with its marketability;
2) The amount of material in a set of training modules will be costly to publish;
3) The inclusion of many different published articles within some of the modules would require permission for duplication from a large number of new authors in the field. Publishers might find this an obstacle to dissemination.

Table 3

OBJECTIVES FOR PEDIATRIC EDUCATION IN THE AREA OF HANDICAPPED CHILDREN AND THEIR FAMILIES

1. To gain sensitivity to handicapped children and their families.
2. To gain awareness of the behavioral characteristics of different handicapped children.
3. To gain familiarity with labels and other terminology used to describe handicapped children.
4. To gain knowledge of the educational opportunities and role of the educator in serving the handicapped child.
5. To gain an ability to communicate and relate to special educators in the field.
6. To learn to function effectively as members of an interdisciplinary team.
7. To become more knowledgeable and skillful in providing general health and medical care for the handicapped child.
8. To gain an ability to use screening, diagnostic, and assessment procedures in order to effectively identify and manage handicapped children.
9. To gain an ability to communicate and effectively plan with parents concerning the developmental and educational needs of a handicapped child.
10. To develop appropriate interviewing and counseling skills for use with families of a handicapped child.
11. To gain an understanding of community resourses available for handicapped children.
12. To become more aware of legal and legislative aspects of handicapping conditions.

III. EVALUATION

We fully acknowledge the many complexities involved in adequately evaluating the effectiveness of both inservice and preservice teacher training programs. The time and expense involved in a comprehensive evaluation system could constitute a separate project. The ultimate question is whether teachers receiving a specific training program provide quality educational services to severely handicapped children. Admittedly, we have not been able to undertake an inservice training evaluation system that allows us to draw definite conclusions concerning the effectiveness of the program. However, we have been systematically collecting data to permit a fairly good indication of the success or failure of our efforts. These inservice evaluation procedures are discussed under the following areas:

1. Competency requirements. The very nature of the modular, competency-based training program presents a format for direct evaluations of student mastery of specified content areas. Accordingly, student mastery is evaluated with respect to both informational and performance competencies.

   Informational competencies require that a student demonstrate mastery of the required reading materials by taking written exams that have both direct and applied questions dealing with the content of each module. These questions (and the required answers) are specifically derived from the objectives central to each module. Accordingly, an evaluation of student mastery is inherent in each instructional module used in the inservice training program. Each student had the opportunity to take a second test after restudying a module if he/she was not satisfied with the grade obtained on the first exam. This component allowed more flexibility and encouraged acquisition of competency. Tables 4, 5, and 6 represent student grades on module exams for Summer, Spring, and Fall 1980, respectively. As can be seen, most students are at the A or B competency level. Figures 11 and 12 summarize student grades on exams throughout the length of the Project and provide the mean score for all students on each exam across all semesters of the Project.

Additionally, demonstrated performance competencies are also included in the program to be used for inservice teacher training. Performance competencies are measured by direct observations of the teacher in a classroom setting and by evaluation of written assignments. Each performance competency is directly related to the content of a specific module. For example, in Module 9, a teacher must demonstrate how to use reinforcers in a training session correctly, a skill taught in Module 2. Figures 13, 14, and 15 illustrate how competencies are related to specific modules.

To assist in measuring actual teaching competencies (as opposed to managerial competencies), teacher proficiency checklists were used by the supervising instructor. However, practicum supervisors found these instruments not to be totally

Table 4

Number of Individuals Receiving Letter Grades in Instructional Module Exams in Spring 1980

	Letter Grade Received				
Module	A	B	C	D	F
1 Right to Education	4	5			
2 Behavioral Approach to Education	3	4	2	1	
3 Programming Engaging Environments	2	2	5	2	
4 Programming for Normalization	7		1		1
5 Assessment Scales	1	3	2		2
6 Writing Instructional Programs	9	1	1		2
7 Measuring Operant Behavior	2	6	1	3	2
8 Evaluation of Operant Behavior	4	3	2	1	3
10 Strengthening Operant Behavior	2	3	1		1
11 Weakening Operant Behavior	5	2		1	
12 Discrimination and Operant Control	5		2		
13 Programming for the Physically Handicapped	1	5	2		
14 Programming Prosthetic Environments	4	1	1	1	
16 Motor Programs	3	1	1		
17 Language Programs			1	1	
18 Self-Help Programs			2		
19 Socialization Programs	3	1		1	
20 Preacademic Programs	2	1			
21 Prevocational Programs					
22 Generalization Training	3	1	1		
23 Schedules of Reinforcement	4	2			
24 The Involvement and Training of Parents and Teaching Assistants	4		1		

Table 5

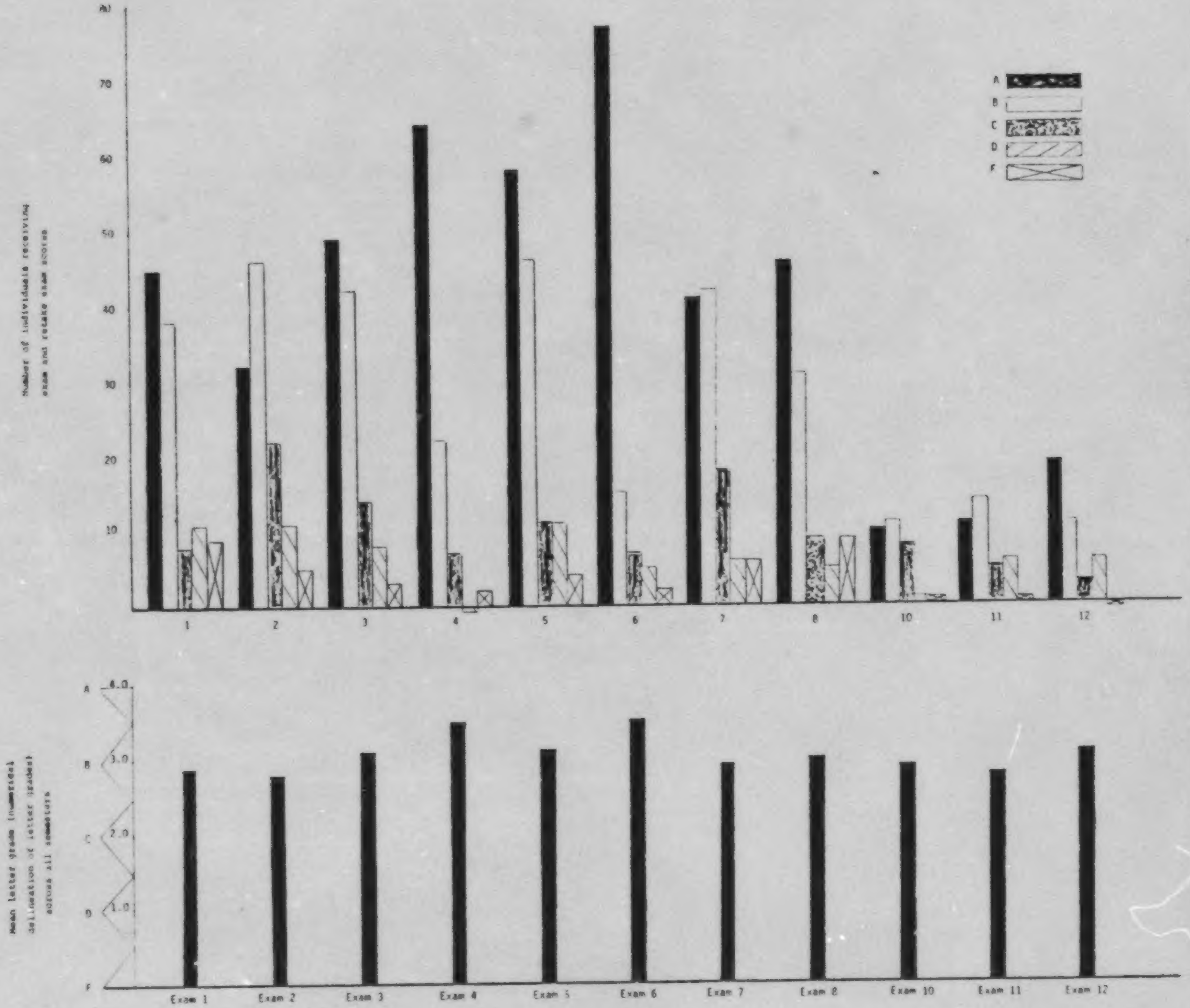
Number of Individuals Receiving Letter Grades in Instructional Module Exams in Summer 1980

Module	Letter Grade Received				
	A	B	C	D	F
1 Right to Education	8	3		1	2
2 Behavioral Approach to Education	4	5	5		
3 Programming Engaging Environments	7	5	1		
4 Programming for Normalization	8	3	1		
5 Assessment Scales	6	6	3	1	
6 Writing Instructional Programs	7	1		1	
7 Measuring Operant Behavior	4	2	3		1
8 Evaluation of Operant Behavior	3	4	1		1

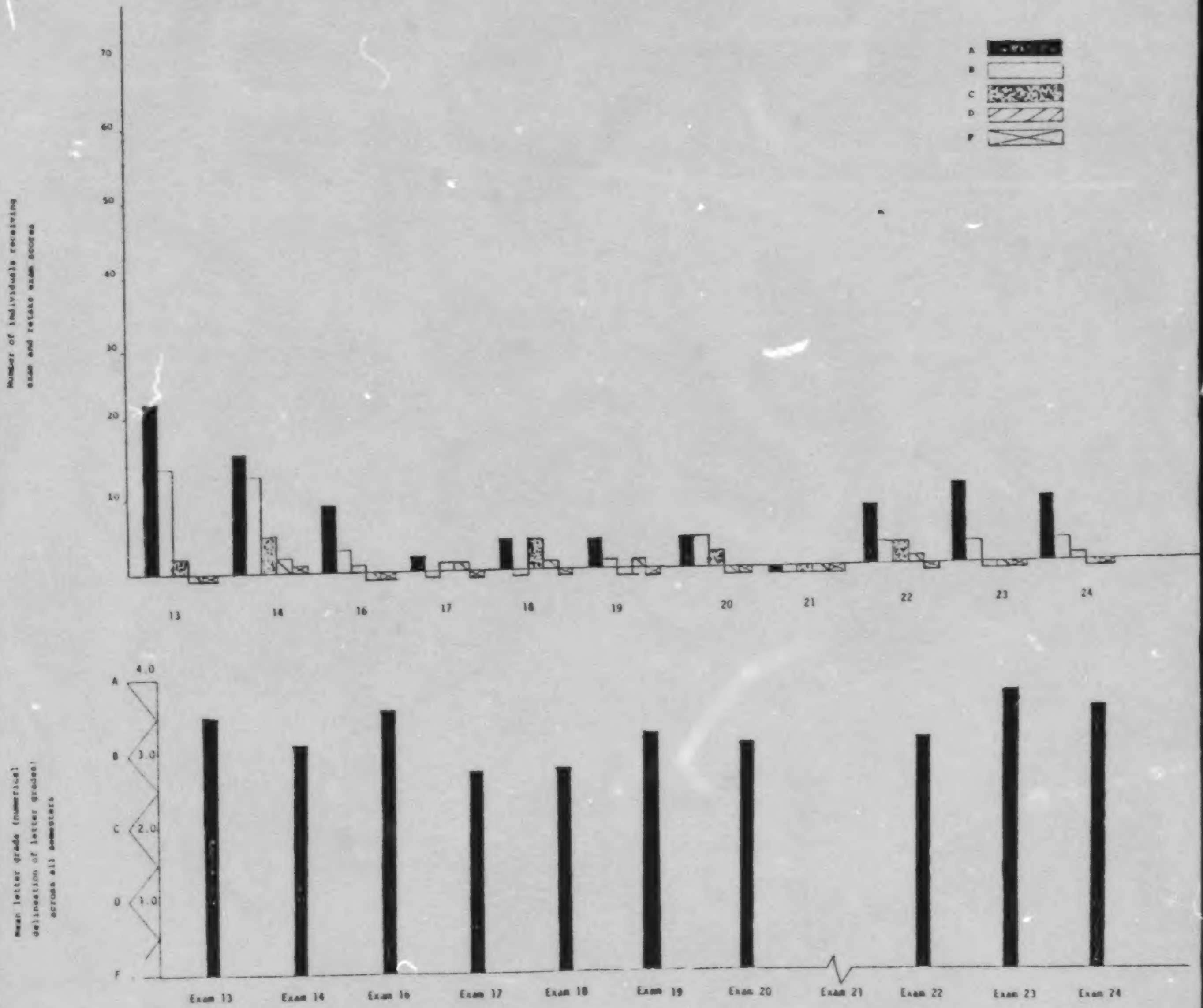
Table 6

Number of Individuals Receiving Letter Grades in Instructional Module Exams in Fall 1980

Module	Letter Grade Received A	B	C	D	F
1 Right to Education	2	7	2	1	2
2 Behavioral Approach to Education	4	6	2	2	2
3 Programming Engaging Environments	8	3			1
4 Programming for Normalization	5	1			1
5 Assessment Scales	10	3	1	3	2
6 Writing Instructional Programs	10	1			
7 Measuring Operant Behavior	4	4	3		1
8 Evaluating Operant Behavior	3	3	3		2
10 Strengthening Operant Behavior	1	4	1		
11 Weakening Operant Behavior	1	2	2	1	
12 Discrimination and Operant Control	2	2		2	
13 Programming for the Physically Handicapped	3	2			
14 Programming Prosthetic Environments	2	2	1		



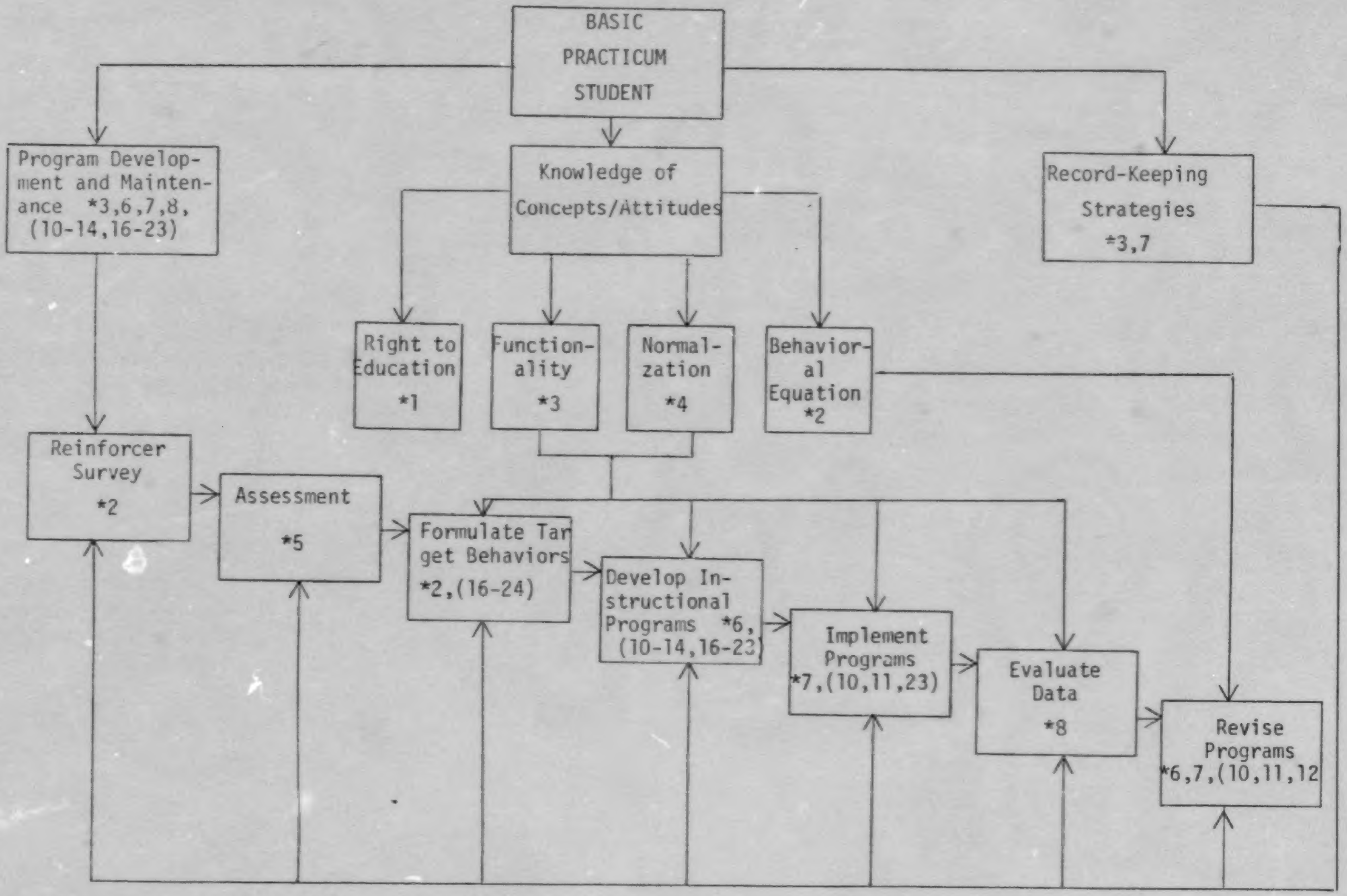
Number of individuals receiving
letter grades and mean exam
grades across all semesters-
Exams 1-12



Number of individuals receiving
letter grades and mean exam
grades across all semesters.
Exams 13-24

Figure 12

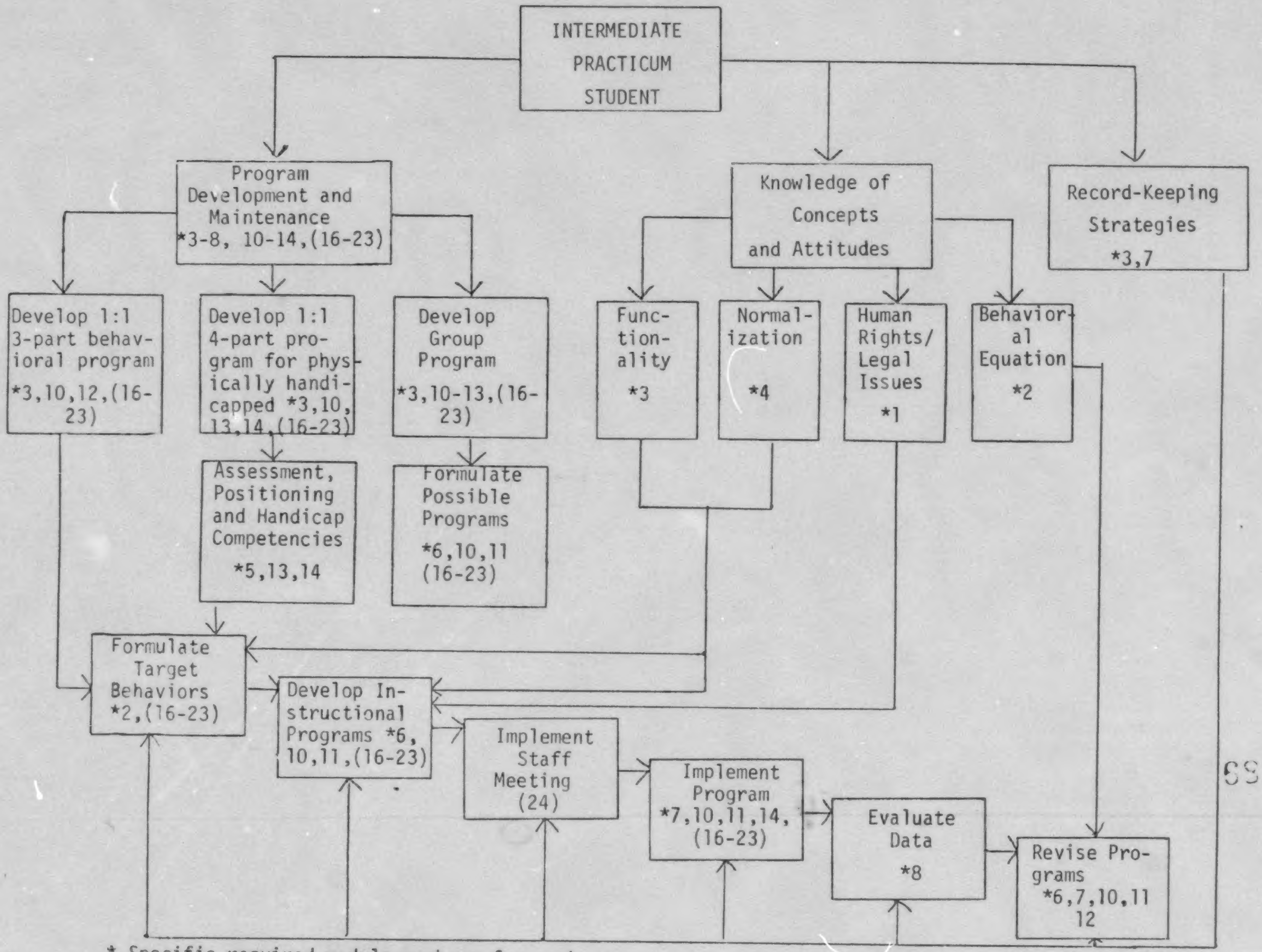
Figure 13


BASIC PRACTICUM STUDENT
Program Development and Maintenance *3,6,7,8, (10-14,16-23)
Knowledge of Concepts/Attitudes
Record-Keeping Strategies *3,7
Right to Education *1
Functionality *3
Normalization *4
Behavioral Equation *2
Reinforcer Survey *2
Assessment *5
Formulate Target Behaviors *2,(16-24)
Develop Instructional Programs *6,(10-14,16-23)
Implement Programs *7,(10,11,23)
Evaluate Data *8
Revise Programs *6,7,(10,11,12

* Specific required module numbers for each competency

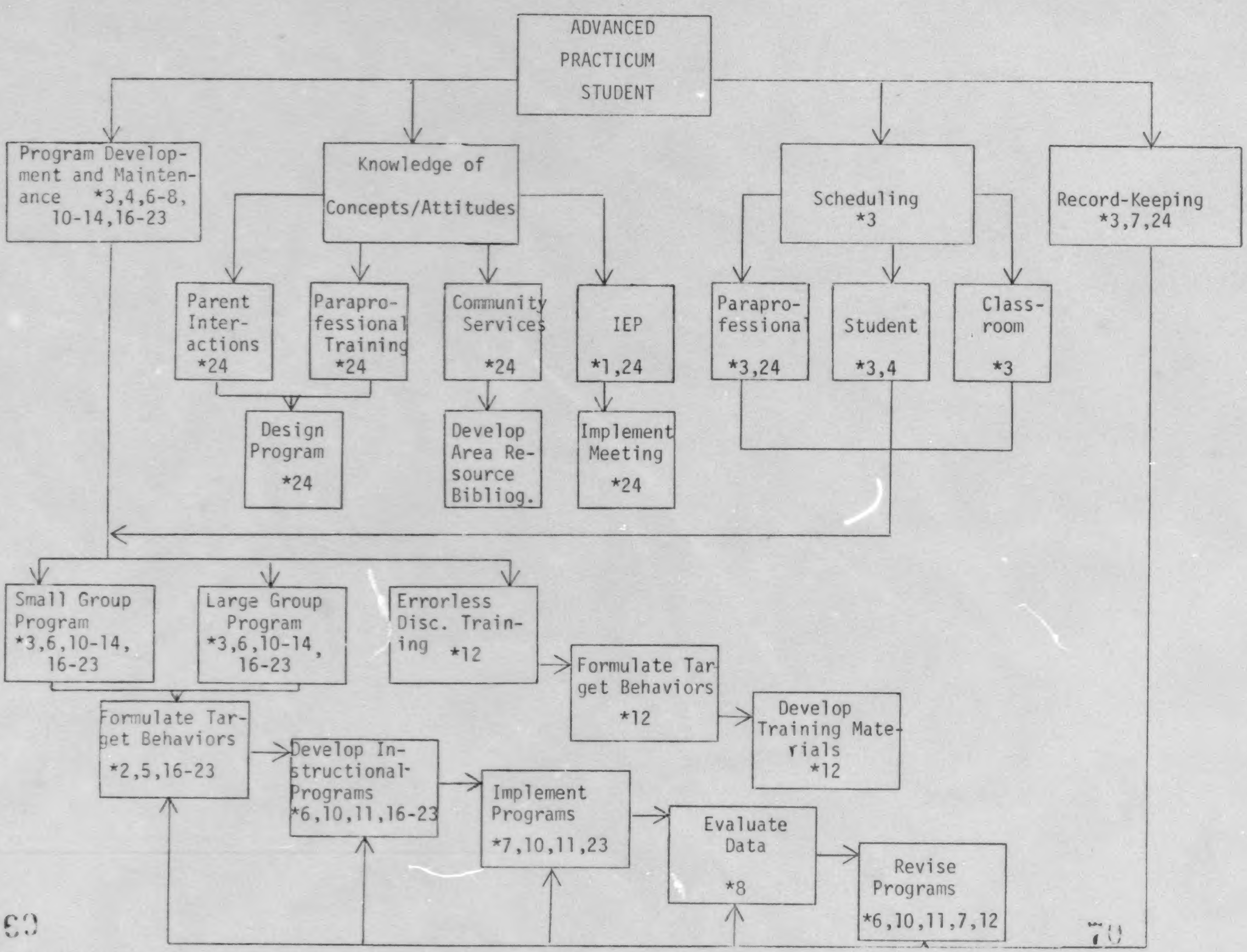
( ) These modules are not required reading for the corresponding information course, however they can be used when a more in-depth resource is needed.

Figure 14


INTERMEDIATE PRACTICUM STUDENT
Program Development and Maintenance *3-8, 10-14, (16-23)
Knowledge of Concepts and Attitudes
Record-Keeping Strategies *3,7
Develop 1:1 3-part behavioral program *3,10,12,(16-23)
Develop 1:1 4-part program for physically handicapped *3,10,13,14,(16-23)
Develop Group Program *3,10-13,(16-23)
Functionality *3
Normalization *4
Human Rights/ Legal Issues *1
Behavioral Equation *2
Assessment, Positioning and Handicap Competencies *5,13,14
Formulate Possible Programs *6,10,11 (16-23)
Formulate Target Behaviors *2,(16-23)
Develop Instructional Programs *6, 10,11,(16-23)
Implement Staff Meeting (24)
Implement Program *7,10,11,14, (16-23)
Evaluate Data *8
Revise Programs *6,7,10,11 12

* Specific required module numbers for each competency

Figure 15


ADVANCED PRACTICUM STUDENT
Program Development and Maintenance *3,4,6-8, 10-14,16-23
Knowledge of Concepts/Attitudes
Scheduling *3
Record-Keeping *3,7,24
Parent Interactions *24
Paraprofessional Training *24
Community Services *24
IEP *1,24
Paraprofessional *3,24
Student *3,4
Classroom *3
Design Program *24
Develop Area Resource Bibliog.
Implement Meeting *24
Small Group Program *3,6,10-14, 16-23
Large Group Program *3,6,10-14, 16-23
Errorless Disc. Training *12
Formulate Target Behaviors *12
Develop Training Materials *12
Formulate Target Behaviors *2,5,16-23
Develop Instructional Programs *6,10,11,16-23
Implement Programs *7,10,11,23
Evaluate Data *8
Revise Programs *6,10,11,7,12

* Specific required module numbers for each competency

adequate for teacher feedback, nor for the type of teaching we were advocating. For this reason, a new checklist was adapted from one used by the Early On Project (Lehr, Hulbert, and Johnson, 1978). This instrument is included in Appendix C. Use during the past semesters seemed to indicate that the checklist worked well and was reliable across observers after some initial training. It also worked well in assisting the supervisor to pinpoint specific trouble areas, work on those specific items with the teacher, and then return to the more global checklist.

With the increased emphasis on group instruction, an additional checklist was designed to assess the teacher's competencies in this area specifically. Variables such as alternating trials between students, appropriate seating arrangement, teaching pace, and handling inappropriate behavior in a group are addressed. A copy of the Group Observation Form is included in Appendix C.

To assess managerial competencies (i.e., skills related to teaching but not actual teaching) several checklists were used. The Teacher Proficiency Checklist II, used for the first two years of the Project, was also based on an instrument of the Early On Project. Although this checklist assessed record keeping and general classroom coordination, Project staff felt that it was not thorough enough in measuring total classroom management. A new General Classroom Observation checklist was designed considering the total approach. Using this form to measure a teacher's competencies required him/her to be responsible for coordinating and integrating all the students in the class, not just a few. A copy of the General Classroom Observation Form is in Appendix C.

Other checklists to assist the teacher in coordinating the classroom and the supervisor in assessing the teacher's performance and management skills include the areas of: 1) assessment procedures; 2) graphic format; 3) reinforcement surveys; 4) record-keeping; and 5) data decisions. These forms are included in Appendix C.

2. Module evaluation. Beginning Fall 1979, Module Evaluation Forms were included in each module. An example of the form is included in Appendix D. It provided an opportunity for input from students enrolled in modular-based classes. The information from these evaluation forms was used by the Project staff to evaluate the effectiveness of the modules and to give us any indication of problem areas. Revisions proceeded from this information. Table 7 represents data that were collected from the trainees on the Module Evaluation Forms. As can be seen from these data, the modules were generally evaluated highly by students across all areas. (Module Evaluation Forms on Modules 16-19 are not available).
3. Accountability system. In addition to evaluating teacher quality, the inservice component was also interested in monitoring how much time was taken by a supervisor to carry our various activities. For the Fall 1980 and Spring 1981 semesters, Project staff intermittently kept track

MODULE EVALUATION RESULTS

* Questions 1-8 are rated on the following scale:
1) Bad news
2) Could be better
3) Okay
4) Pretty good
5) Outstanding

Mean Scores

Modules	1	2	3	4	5	6	7	8	10	11	12	13	14	20	21	22	23	24
1) How well did the instructional competencies inform you of the content of the module?	4.2	4.1	4.4	4.3	4.3	4.6	4.8	4.6	4	4.5	4	4.3	4.3	5	2	4	3	4
2) How well prepared and organized was the module.	4.3	4.1	4.4	4	4.3	4.1	4.2	4.5	4	4.5	4	4.6	4.3	5	3	4.2	4	4
3) Adequacy of the materials in the module.	4.3	4.5	4.6	4.5	4	3.8	4	4.5	4.5	4.5	4	4.6	4.3	5	2	4.1	4	4
4) Relevancy of the module to current classroom teaching.	3.2	4	4	3.5	4	4.6	4.8	4	4	4	3	4	[illegible]	5	3	4.4	5	4.3
5) Relevancy of module to professional growth (i.e. future use).	4.3	4.5	4.4	3.8	4	4.3	4.8	3.5	3.5	4	3	4.3	3.6	5	3	4.4	5	4.6
6) Interest level of the module.	3.8	4	4.2	4.3	3.7	3.8	4	4	4	4	3	4.3	3.6	5	3	3.6	5	4.3
7) Fairness and relevancy of the exams.	4	4	4	4	4	3.8	4.3	4.6	3.5	3.5	3	4	4	5	3	2.8	4	4
8) How well the self-quizzes prepared you for the exam.	4	4	4.4	4.1	4.2	4	3.6	4.6	3.5	3	3	4	4	4	3	3	2	3
* Question #9 was rated on a 1-5 scale: 1 = very easy; 5 = too difficult.													3.3		2			
9) Rate the difficulty of this module.	3.8	3.1	3.4	3.3	3.3	3	4	3.8	3.5	3.5	3	3.3	3.3	4	2	3.6	4	3.3
* Question #10 was rated on a 1-4 scale: 1 = not enough; 4 = way too much.																		
10) Rate the amount of information given in the module.	2.6	2.1	2.2	2.6	2.3	2.3	3	3	2.5	2.5	2	2.3	2.3	4	1	3.2	3	3
* Question #11 had a 1-5 scale: 1 = not at all clear; 5 = outstanding.																		
11) Rate the clarity or the information presented in the module.	3.8	4	4	3.6	3.7	3.6	3.6	4	4	3.5	3	4	3.3	5	3	3.8	4	4

Module Evaluation Results

Table 7

of how much time was spent each week in the following areas: 1) student observation; 2) grading and writing practicum feedback; 3) exam administration and grading; 4) travel, 5) revising modules; and 6) general correspondence and document writing (e.g., information for the progress reports, Procedures Manual). Estimates of these tasks are shown in Table 7.

4. Evaluation of grading contingencies. The Project coordinator and David Esquith, a doctoral student in the Department of Special Education, initiated a study entitled, "Effects of two grading contingencies on practicum assignments with trainees in a severely/multiply handicapped program." The two strategies examined were: 1) students received their final grade for the first product they submitted, and 2) students were allowed to resubmit their work until A-level criterion was reached. The results of the study will provide valuable information for teacher training programs and evaluation. Appendix E contains an abstract of the study.

IV. PROJECT ORGANIZATION AND COORDINATION WITH OTHER AGENCIES

A. Organization and structure at the University of Kansas. Major organizational structure for the Project is presented in Table 9. The table shows the relationship of Project personnel to the University of Kansas. The Project director, Doug Guess, was responsible to H. Rutherford Turnbull, III, Chairperson of the Department of Special Education at the University. The Project coordinator, Fredda Brown, was supervised by the Project director. Ms. Brown assumed the Project coordinator position when Jennifer Holvoet left in the Summer of 1980. Doug Guess and the Project coordinator jointly supervised Lesley Fernandez and Gayle Yelenik, the two teacher trainers. Ms. Yelenik joined the Project staff in the Summer of 1980. Dr. Guess provided supervision in regard to their general job performance as well as their relationship with other agencies. The Project coordinator provided overall supervision in relation to specific Project assignments. The Project secretary (Marianne Watkins) was supervised by both the Project director and the Project coordinator.

B. Coordination with the Kansas State Department of Special Education. The teacher inservice training component of the Project was coordinated with Phyllis Kelly, State Coordinator of the Severely and Multi-Handicapped at the Kansas State Department of Education. Dr. Kelly was responsible to James Marshall, Director, State Department of Education. Mr. Marshall and Professor Turnbull shared overall responsibility

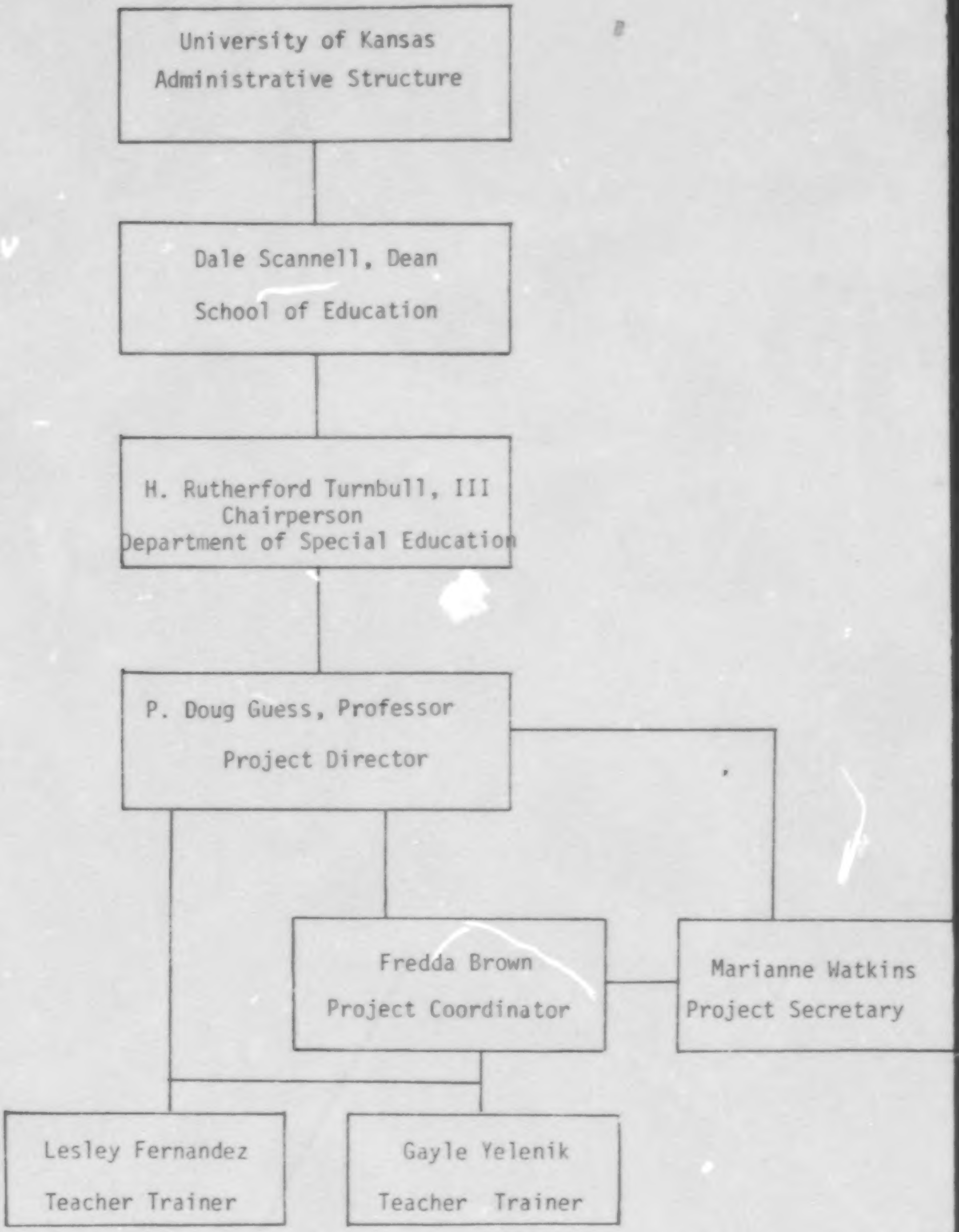
Table 8

Number of Hours (three one-week samples) / Trainer in Specified Activities for Fall 1980 and Spring 1981

	Week	Student Obser-vations	Grading & Writing feedback for Practicum	Administration, Grading & Writing Exam Feedback	Travel	Module Revisions	General Corres-pondence/ Summary Work	Phone visits, Staff development, Office work, & etc.
Trainer 1	1	0	1.5	11.75	0	5.5	0	21.25
	2	1.5	.75	0	.67	0	14.0	23.0
	3	1.5	6.5	0	.67	0	6.5	24.8
Trainer 2	1	13.5	13.0	.75	15.0	0	0	0
	2	0	2.25	1.0	0	1.5	8.25	27.0
	3	12.0	6.0	1.0	8.5	0	0	12.5
Trainer 3	1	2.0	6.75	3	1.0	3.0	19.5	5.75
	2	10.5	18.0	0	14.0	0	4.0	0
	3	15.0	4.0	0	15.0	0	6.0	8.0
Total for 3 Weeks		56.0	58.75	17.5	54.84	9	58.25	122.3
% Time		15%	16%	4%	15%	2%	16%	34%

Table 9

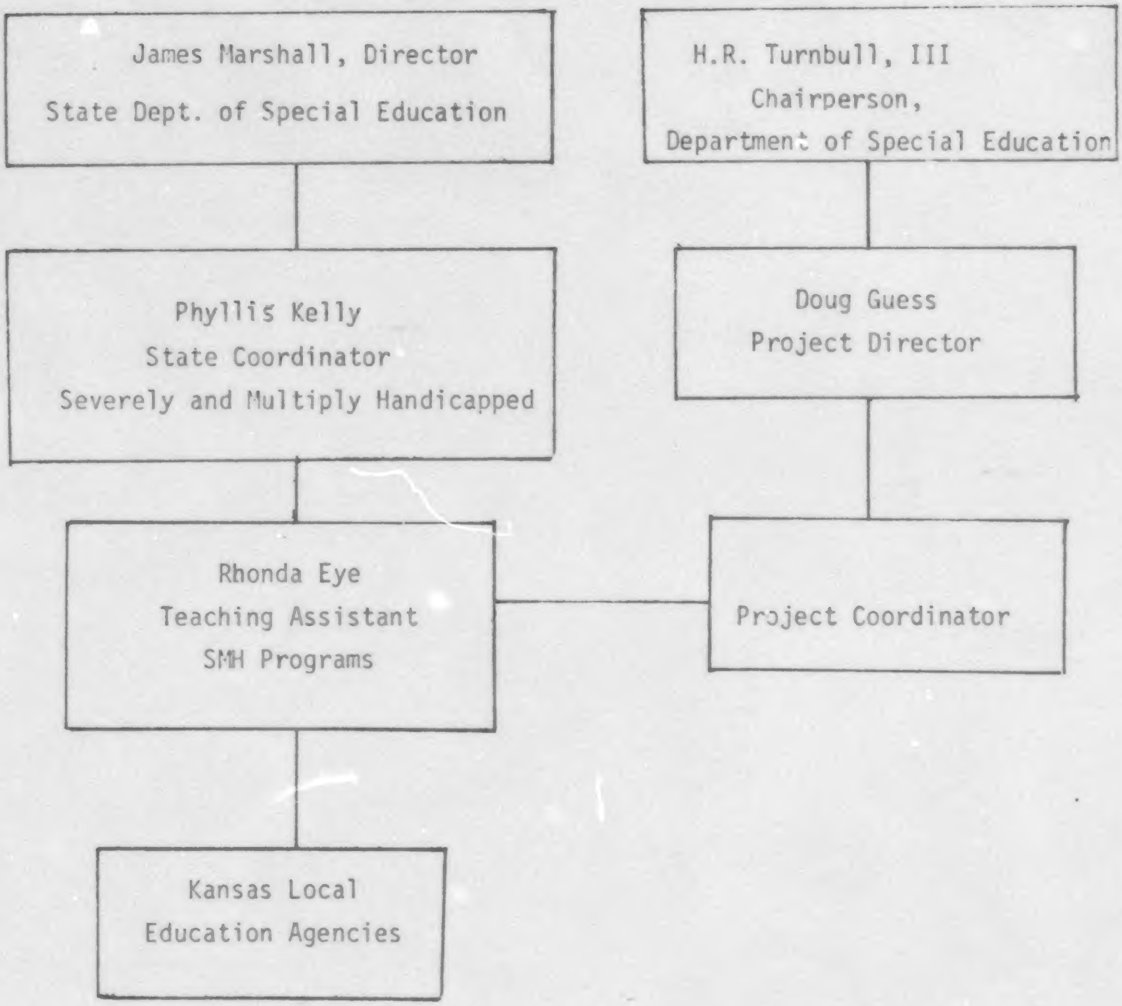
Organizational Chart of Project Personnel


University of Kansas
Administrative Structure
Dale Scannell, Dean
School of Education
H. Rutherford Turnbull, III
Chairperson
Department of Special Education
P. Doug Guess, Professor
Project Director
Fredda Brown
Project Coordinator
Marianne Watkins
Project Secretary
Lesley Fernandez
Teacher Trainer
Gayle Yelenik
Teacher Trainer

for the implementation of the inservice component of the Project. Contact with Kansas local education agencies (LEA's) was accomplished through the State Coordinator of the Severely and Multihandicapped and the technical assistant, Rhonda Eye. The Project director related directly to Dr. Kelly concerning development and implementation of the statewide inservice training program. Ms. Eye, technical assistant to severely/multiply handicapped programs in the State of Kansas, worked directly with Project personnel in the coordination of the statewide inservice teacher training effort. Ms. Eye assisted in conducting workshops, providing supervision in some practicum sites, and importantly, serving as a direct liaison between the Project coordinator and local education agencies. This coordinated effort between the Kansas State Department of Education and the Project was considered vital to the success of the Project. Coordination with the Kansas State Department of Education and LEA's is shown in Table 10.

Table 10

Project Coordination with the Kansas State Department of Education and LEA's


James Marshall, Director
State Dept. of Special Education
H.R. Turnbull, III
Chairperson,
Department of Special Education
Phyllis Kelly
State Coordinator
Severely and Multiply Handicapped
Doug Guess
Project Director
Rhonda Eye
Teaching Assistant
SMH Programs
Project Coordinator
Kansas Local
Education Agencies

Summary

The purpose and intent of this special project was to accomplish two major goals: 1) To design and provide inservice training to teachers of the severely handicapped in the state of Kansas; and 2) to further develop the Kansas University curriculum for preparing teachers of the severely handicapped. These goals have been met and demonstrated in several ways:

Number of teachers served by the Project. A total of 39 teachers completed the Master's degree requirements. Another 85 teachers have completed the requirement for certification only. There are currently 61 additional trainees in the process of completing certification and/or Master's degree requirements.

Module development. A total of 27 modules have been developed that cover the performance and informational competencies identified as relevant to teachers of severely handicapped students. These modules comprise the content of seven special education courses and are closely coordinated with on-campus lecture classes.

Number of students and teachers in public schools. The rapid growth of classes for severely multiply handicapped children in the state reflects the progress made in meeting the zero reject and least restrictive environment provisions of PL 94-142. In 1976, there were 30.6 teachers and 257 students in public school classes for the severely multiply handicapped. In 1980, these numbers increased to 83 teachers and 350 students in public school classrooms.

Development of the Procedures Manual. A Procedures Manual describing how to design and implement an inservice and modified inservice program has been developed. The information contained in this product will be of great assistance to those individuals beginning, as well as those already involved in an inservice program. The content of the Procedures Manual is applicable not only to teachers of the severely handicapped but to teachers across all populations of students.

Appendix A

(Revised Modules)

REVISED
MAY 80

BASIC CLASSROOM PARTICIPATION

(Module 9)

Revised by:
Pat Welch, Jennifer Holvoet and Doug Guess
Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped
The University of Kansas Department of Special Education

Original by:
Bonnie Utley, Trudy Rinne, and R. Don Horner
Professional Training Program Development Unit
Department of Special Education
The University of Kansas

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ⓒ 1978 Statewide Inservice Training
Program for Teachers of the
Severely Multiply Handicapped.

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Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped

Department of Special Education, The University of Kansas
The University of Kansas Medical Center

PRINCIPAL INVESTIGATORS: Doug Guess, Phyllis Kelly

PROJECT DIRECTOR: Doug Guess

PROJECT COORDINATOR: Jennifer Holvoet

CURRICULUM DEVELOPERS: Fredda Brown, Jennifer Holvoet and Pat Welch

PRACTICUM SITE SUPERVISORS: Fredda Brown and Pat Welch

Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped
The University of Kansas Department of Special Education

Competency Specifications for:

BASIC CLASSROOM PARTICIPATION MODULE

EDUCATIONAL GOAL

To provide experiences in active interaction with special education teachers and severely handicapped persons in special classrooms located in public schools and residential settings, and to teach the application of information obtained from the Right to Education, Behavioral Approach to Education, Programming Engaging Environments, Programming for Normalization, and Assessment Modules to the teaching of appropriate behaviors to a single severely multiply handicapped child.

PERFORMANCE COMPETENCIES

The student teacher completing this module should apply the information acquired through the readings of Modules 1-5 by:

1. Determining from various sources if violations of a student's right to education have been made.
2. Identifying the antecedent, behavior, contingency, and consequent responses when shown an instructional program.
3. Engaging in a procedure leading to the identification of conditioned or unconditioned stimuli which may serve as reinforcers when made contingent upon, and presented immediately after, a target behavior.
4. Identifying the use of a specific training procedure when given examples of chaining, shaping, extinction and time-out.
5. Composing target behaviors appropriate to a student after observing the student during assessment.
6. Developing a record-keeping system meeting IEP requirements.
7. Designing, in writing, an ideal classroom to include the basic curriculum areas and the principles of normalization and functionality.
8. Administering an assessment and choosing appropriate target behaviors from the assessment.
9. Understanding and applying the principles of normalization and functionality.
10. Learning to assess in specific domain areas and to use informal evaluations.
11. Defining behavioral acts specifically enough for reliability.

12. Developing an instructional program.

13. Designing measurement and evaluation systems to be used with instructional programming.

14. Evaluating the effectiveness of instructional programming.

ASSIGNMENT 1

Prerequisite Readings: None

Assignment: Write a 1-3 page description of an ideal classroom incorporating your own ideas and any suggestions from the modules which you have particularly liked.

Rationale: This is part of an overall evaluation for the module. It also should help your practicum supervisor structure your class the way you wish to have it.

Criteria: Graded as acceptable/not turned in. (One try)

ASSIGNMENT 2

Prerequisite Readings: Module 1

Assignment: Determine from various sources, (i.e. parents, administrative records), the educational background of one student. Describe how the student's right to education may have been violated and how it could be improved.

Rationale: To understand components of Public Law 94-142 and its implications for each student.

Criteria: Three to four major components included. (One try, however, revisions will be required until criterion is met.)

ASSIGNMENT 3

Prerequisite Readings: Module 2

Assignment: View program #1 on video tape. Describe the following components of the taped instructional program:

a) antecedent
b) behavior
c) contingency
d) consequence

Rationale: To learn to label basic instructional programming components.

Criteria: 100% correct identifications. (Two tries, final grade will be the best of the two. Revisions will be required until criterion is met.)

ASSIGNMENT 4

Prerequisite Readings: Module 2, and Teaching a Child to Imitate, Streifel.

Assignment: Implement the reinforcer survey (pages 8-11) with one student using at least 5 edibles.

Rationale: To learn a procedure useful in identifying potential reinforcers.

Criteria: 90% achievement on Reinforcer Survey Checklist. (One try. Revi- will need to be made before going on to Assignment 5.)

Special Instructions:
1) Some modifications to the procedure may be necessary for the physically handicapped student.
2) See next page for description of factors considered in grading (Reinforcer Survey Checklist).

REINFORCER SURVEY CHECKLIST

Teacher: ______________________ Date: ____________

Supervisor: ____________________

Environmental Factors

1. Is area prepared for survey? Yes No
2. Is the positioning appropriate for the student? Yes No
3. Are precautions made for the possible occurance of inappropriate behavior? (i.e. shield, items on tray, etc.) Yes No
4. Are the items chosen age-appropriate for the student? Yes No
5. Was a trial taste of each item given prior to administration of the survey? Yes No

Administration

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Point to each item															
2. Clear Cue															
3. Data Recorded															
4. Position Noted															
5. Rearrange Items															

Evaluation

1. Did the teacher tally the score? Yes No
2. Checklist Score __________
3. Reliability Score __________

ASSIGNMENT 5

Prerequisite Readings: Module 2 and Teaching a Child to Imitate, Streifel.

Assignment:
1) Implement an additional reinforcer survey with the same or an additional student using at least 5 activities.
2) Determine the reliability of trainer and observer's scores.

Rationale: To learn to determine the reliability of training procedures.

Criteria: 90% reliability. Formula and figure work must be accurate. (One try, however revisions must be made until criterion is met.)

Special Instructions:
1) All items used in the survey should be age appropriate materials.
2) Some modifications to the procedure may be necessary for the physically handicapped student.

ASSIGNMENT 6

Prerequisite Readings: None

Assignment:

1) Substitute one of the preferred reinforcers from the Streifel Reinforcer Survey in place of another reinforcer in an existing program. Run program for at least 5 days.

2) Compare previous 5 days of data with this data using the new reinforcer and evaluate the effect of the change in the student's behavior.

Rationale: To learn at least one way to determine the effects of a reinforcer and to show that, in order to be a reinforcer, the item or activity must increase a behavior.

Criteria: 100% correct completion of Reinforcer Effectiveness Checklist. (One try, however revisions must be made until criterion is met.)

Special Instructions: If there are no data-based program presently being run in the classroom, the supervisor will help the teacher begin a simple data collection procedure. Five days of data should be collected with a randomly chosen reinforcer, and then change the reinforcer to one that was preferred in the survey. At this point, a Reinforcer Effectiveness Checksheet should be completed.

Reinforcer Effectiveness Checklist

Teacher: ______________________________

Supervisor: ___________________________ Date: __________

Student:

Program:

Previous reinforcer:

Summary of last 5 session scores

Session #					
Score					

Preferred reinforcer:

Summary of 5 consecutive session scores with change of reinforcer

Session #					
Score					

What effect, if any, did the reinforcer change have on the rate of the behavior?

ASSIGNMENT 7

Prerequisite Readings: Module 2

Assignment: View video programs 2-4 and answer the questions on page 13.

Rationale: To identify specific training and deceleration procedures when shown instructional programs.

Criteria: 90-100% correct identification. (Two tries, with feedback given following the first effort. Final grade will be the best of the two. Revisions will be required until criterion is met.)

ASSIGNMENT #7

1. In video program #2, which of the following procedures were used to train the student to sign ice cream?

   a. shaping
   b. backward chaining
   c. differential reinforcement
   d. positive reinforcement

2. The trainer in video #2 also used a procedure to decelerate an incorrect response. Which of the following were employed?

   a. punishment
   b. time-out
   c. withdrawal of positive reinforcement
   d. extinction

3. The brushing teeth program shown in video program #3 is an example of which of the following types of procedures?

   a. forward chaining
   b. backward chaining
   c. negative reinforcement
   d. shaping

4. Video program #4 pictures a student learning to follow directions. What procedures are being used to accelerate this response?

   a. positive reinforcement
   b. forward chaining
   c. shaping
   d. modeling

5. Also in video program #4, what technique was implemented to decelerate the inappropriate behavior of tantrumming?

   a. extinction
   b. withdrawal of positive reinforcement
   c. response cost
   d. overcorrection

ASSIGNMENT 8

Prerequisite Reading: Module 4

Assignment: View video program 5. Describe how this program maximizes the principles of normalization and functionality.

Rationale: To learn to identify normalization principles in classroom structure and programming.

Criteria: Description must include components shown for both normalization and functionality. (One try, however revisions will be required until criterion is met.)

ASSIGNMENT 9

Prerequisite Readings: Module 4

Assignment: Describe a present program in your classroom which could be more normalizing and functional. Consider setting, materials, cues, etc. Note changes to be made.

Rationale: To learn to apply principles of normalization and functionality to classroom structure and programming.

Criteria: Description must be a feasible alternative and include all components listed above. (One try, however, revisions will be required until criterion is met.)

ASSIGNMENT 10

Prerequisite Readings: Module 5

Assignment: 1) Select and list one appropriate formal assessment scale for each student in the class.

2) Administer a formal assessment to one student. Your supervisor will observe a section of 15-20 trials of direct testing.

Rationale: To learn the proper administration of formal assessments.

Criteria: 90% proficiency on assessment administraction checklist. (1 try)

Special Instructions: 1) At least 3 of the assessments chosen must be included in Module 5. The one chosen for observation must also be listed.

2) It is preferred that therapists (occupational, speech, physical) administer assessment domains outside their field of expertise.

3) See next page for description of factors considered in grading (Assessment Administration Proficiency Checklist).

Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped
Department of Special Education, The University of Kansas

ASSESSMENT ADMINISTRATION PROFICIENCY CHECKLIST

Student Teacher ______________________________

Practicum Supervisor ______________________________

Student Name ______________________________

Assessment used ______________________________

PREPARATION

1. Yes No Instrument chosen includes those behavioral areas which are stressed in this classroom.

2. Yes No Assessment area is prepared.

3. Yes No Assessment area provides appropriate setting for chosen assessment.

4. Yes No Use/non-use of reinforcement is pre-determined.

5. Yes No Use/non-use of reinforcement is appropriate to evaluate chosen skill areas.

POST ASSESSMENT

12. Yes No Totals score for assessment.

13. Yes No Profiles assessment score (if necessary).

14. Yes No Determines target behavior areas.

15. Yes No Adds assessment informations to STEP file.

20 TRIAL SAMPLE

6. Presents stimulus for each response.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
YES																				
NO																				

7. Use/non-use of reinforcement according to behavioral definition.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
YES																				
NO																				

8. Interrupts each response which is incompatible.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
YES																				
NO																				

9. Records the results of each trial.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
YES																				
NO																				

10. Proceeds to next trial.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
YES																				
NO																				

11. Notes items needing other sources.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
YES																				
NO																				

Total Yes
______________________ x 100 = ______%
Total Yes & No

90-100%	Excellent
80-89%	Good
70-79%	Fair
60-69%	Poor
59-below	Unacceptable

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ASSIGNMENT 11

Prerequisite Reading: Module 3

Assignment:
1) Choose 1 target behavior missed on the assessment for each domain (motor, communication, self-help, socialization, and preacademic).
2) Re-write, if necessary, the objective in terms of functionality and determine materials and objects that would maximize functionality when training that skill.

Rationale: Standard assessments rarely address themselves to the normalized or functional use of a skill. Research has shown that the severely handicapped acquire skills more quickly and generalize better when trained in a functional manner. Therefore, many of the objectives from the assessment will need to be revised before program implementation.

Criteria: All components must be completed. Graded as acceptable/not turned in. However, revisions will need to be made until assignment is acceptable.

Special Instructions: See next page for example of an objective and format required.

Assessment Used: Portage

Domain: Motor

Behavior Tested: Builds tower of 5-6 blocks

Skill: (70) Stacking

Student: 9 year-old severely-multiply handicapped female.

Possible functional materials to use to train this skill to the student:
cups, plates, utensils, books, magazines, washcloth.

Example functional objective to train this skill to this student:

Given 5 books resting horizontally on a table in scattered arrangement, and within arms reach of the student, and given the verbal cue, "(Name), stack the books," the student will position one book horizontally in front of him/herself and stack each of the other books horizontally in front of him/herself so all four sides match within 15 seconds for 9 of 10 trials per day for 2 consecutive days.

Assessment Used: Callier-Azuza

Domain: Cognition

Behavior Tested: 5 (B). Anticipates a whole object by seeing only a part

Skill: Object permanence

Student: 16 year old male, no physical involvement, severely multiply handicapped

Possible functional materials to train this skill to student:

Items which would most normally be partially covered (i.e. toothbrush under washcloth, edible under napkin, pencil under paper, comb or soap under towel).

Example functional objective to train this skill to student:

When stood before a sink cabinet upon which a comb is placed partially covered (1" of narrow end visible) with a hand towel, and given the verbal cue, "(Name), get the comb," the student will reach and grasp the comb and pull it into full view within 10 seconds, 90% of the trials for 3 consecutive sessions.

ASSIGNMENT 12

Prerequisite Reading: None

Assignment: 1) Choose 3 target behaviors missed on the assessment.

2) With the help of your supervisor, task analyze the deficient behaviors and reassess to determine programming needs for each skill.

Rationale: Assessments frequently provide testing in only 'general' skill areas. A more specific testing is required in order to determine terminal behavioral objectives for programming.

Criteria: This is a learning assignment and will be graded in regard to completion only.

The task analysis must specify the student's behavioral steps in completing the task. A written description of the results of the reassessment must also be turned in.

ASSIGNMENT 13

Prerequisite Readings: Module 5

Assignment: Choose one of the informal assessments provided in Module 5. Administer it to one student and determine 2 target behaviors for the domain observed.

Rationale: Formal assessments are not always tailored to fit individual classroom and students' needs. Teachers will need to learn to implement and develop informal evaluations to test specific areas of need.

Criteria:
1) Correct completion of evaluation form
2) 100% correct components for each target behavior.

ASSIGNMENT 14

Prerequisite Readings: Module 2; Assessment Explanation Sheet

Assignment: View video program 6. From the explanation sheet and the administration of the assessment shown, what target behaviors might be appropriate for this student? (i.e. what skills could be programmed?)

Rationale: To learn to determine target behaviors from an assessment and to assess skill areas of a severely multiply handicapped student.

Criteria: Three target behaviors, each having the five basic components of 1) behaver; 2) conditions of the behavior; 3) the behavioral act; 4) object of the behavior and 5) criterion for success. (Two tries. Feedback will be given following the completion of the assignment. The final grade will be the better of the two. Revisions will be required until criterion is met.)

ASSIGNMENT 14

Assessment Explanation Sheet CALLIER-AZUZA

PERCEPTUAL DEVELOPMENT

A. Visual Development

6. (A) May track objects horizontally and vertically. *Given a brightly colored object held at eye level, the student will make eye contact with the object for 3 seconds and follow the appearance of the object 1) from center (0 degrees) through a horizontal arc of at least 30° and 2) from center (0 degrees) through a vertical arc of at least 30°.*

   (B) Shifts visual attention from one object to another when two or three are presented (scanning). *Given two objects held at eye level, the student will make eye contact with one object for at least 1 second and shift contact to the second object within 5 seconds.*

7. (A) Attempts to secure objects beyond his/her reach. *Given an object of potential reinforcement placed on the table in front of the student, the student will attempt to obtain object within 10 seconds.*

   (B) Turns objects in his/her hand and explores them visually. *Given an object of potential reinforcement, the student will grasp object, and look at object for at least 3 seconds with one movement of the object in the hand.*

8. (B) Matches identical objects. *Given a set of two objects on tray in front of student, and given a match to one of the objects with the verbal cue, "Show me", the student will indicate which object is the same by touching or placing the sample object beside it.*

LANGUAGE DEVELOPMENT

A. Receptive Language

6. (A) Follows simple instructions communicated in formal language. *Given the verbal cue, "Come here," the student will mobilize toward the trainer within 10 seconds, and will move at least one-half the distance toward the trainer within 1 minute.*

   (B) Understands several nouns and action words communicated in formal language. *Given the verbal cue of "(verb)", the student will begin the action within 3 seconds and will complete the requested task within 10 seconds. (e.g. open, take out, run)*

   (D) May respond to name or name sign communicated in formal language. *Given the verbal cue of "(Name)", the student will attend to the trainer within 3 seconds by ceasing activity and/or obtaining eye contact.*

8. (A) Identifies or obtains when asked, three familiar objects in his/her surroundings used in the course of the daily routine. *Given the verbal cue of "(Name), get the (objects)" the student will move toward the object within 5 seconds. (e.g. cup before snack, towel after washing hands, ball before play)*

Prerequisite Readings: Module 2, program information sheet

Assignment: View video program #7. Specify, in detail, the cue given to the student, and the behavioral act for each skill being programmed.

Rationale: Experience in writing behavioral definitions in preparation for program development.

Criteria: Clear and precise behavioral definitions. Supervisor should be able to take reliability after reading the definitions.

Special Instructions: An explanation and example of specifying behavioral definitions is provided on page 26.

ASSIGNMENT 15

Explanation & Example

Specifying behaviors is important in many aspects of our lives. Baker, 1978, explains that most of us specify behaviors daily. A recipe specifies what actions will be taken clearly enough to allow someone else to know exactly what should be done. We specify directions to our house to allow our friends to visit. When setting an appointment we may say, "I'll see you sometime this afternoon," or we may specify what 'sometime' is by saying "I'll see you at 2:30 this afternoon."

If the teacher has properly specified the behavior, anyone who reads it should know exactly what the behavior is and should be able to identify correct or incorrect responses when either occurs.

Behavior	Specified Behavior
"waves good-bye"	Raises extended dominant arm to chest level, flexes elbow, opens dominant hand, and moves forearm in an 'up and down' motion twice, and returns arm to resting position beside torso."
"pushes the ball"	With flexed arms, hands make simultaneous contact with the ball and arms extend quickly, causing ball to move from contact with the fingers for a distance of at least 2 inches.

Program Information Sheet

In this video (#7), a student is being trained to develop two skills. He is first asked to achieve a sitting position with an erect head and is then required to identify an object by touching it. These programs would most appropriately be run with trials spaced throughout the day. However, for video taping, the trials were massed. Objects to be labeled were functional for Mark's environment.

The sitting program is being run using a procedural training technique. First a verbal cue only is given (V), then a verbal cue with a prompt (P), and finally a complete put-through (T) is provided as necessary. The object label training program is using positive reinforcement and the withdrawal of reinforcement to increase correct responses.

ASSIGNMENT 18

Prerequisite Readings: Modules 2 and 3

Assignment: Using behaviors seen as deficient in the assessment, determine two skills which could be programmed in one instructional setting.

Rationale: Experience in combining skills into clusters in preparation for program development.

Criteria: The following will be considered when grading: 1) the cohesiveness of the programs chosen and 2) the appropriateness of the scheduling at one setting.

ASSIGNMENT 19

Prerequisite Readings: Assignment 18 and Program Development Form

Assignment: Devise a program for each skill chosen using the following Program Development Form.

Rationale: Experience in developing instructional programming.

Criteria: The following will be considered in grading: 1) program design (does it look like it will work), 2) compatibility of programs, 3) functional and age-appropriate materials, and 4) appropriateness of measurement system to the program.

PROGRAM DEVELOPMENT FORM

1. Title of Program:
   (What skill is being taught, include domain)

2. Author:
   (Your name as the developer, and any others who helped; consultants, curriculum manuals, etc.)

3. Person in Charge of Program:
   (Who is going to implement and evaluate the program?)

4. Terminal Behavioral Objective:
   a) What cues will be given to elicit the behavior?
   b) What behavior is expected?
   c) Is there an object of the behavior?
   d) How well must the student do to complete the program?

5. Rationale:
   (Why is this skill important for the student to learn?)

6. Suggested Functional Scheduling:
   (When could the program be scheduled so that it occurs in the student's environment at a time and place when that skill should naturally occur?)

7. Materials Needed: (What materials need to be available in the area for training in order to proceed smoothly?)

8. Cue:
   a) What will be said to the student?
   b) What objects/materials will be presented to the student?
   c) What position will student and/or trainer be in?

9. Data Recording:

   a) How will correct responses be noted on the data sheet?

   b) How will incorrect responses be recorded?

   c) Will any other types of responses be recorded? (i.e. prompts, no-response, shape)

10. Baseline Procedures: Baseline is taken to provide the teacher with a complete picture of what the student can do in regard to this program before training is begun. It will help determine the effectiveness of the program. To take baseline, the procedures are run according to the terminal behavioral objective. Reinforcement is generally given for correct responses (to avoid extinction of the known behavior). However, if the program to be developed is to use reinforcers as its only tactic for increasing the behavior, do not use reinforcement in baseline.

Trials in which the student responds incorrectly or fails to respond at all are usually given no consequence. To develop baseline procedures for the program, determine the following:

a) What cue(s) will be given to the student to elicit the behavior?
b) What is the trainer to accept as a correct response?
c) What consequence will be provided for a correct response?
d) What should be recorded on the data sheet when a correct response is made during baseline?
e) What should the trainer do if an incorrect or incomplete response is given?
f) How should an incorrect response be noted on the data sheet?
g) Is a trial with no response consequated or recorded differently than an incorrect trial?
h) How many trials/sessions of baseline should be run?

Note: The standard of '3' baseline sessions is not always appropriate. Baseline should be continued until the data is stable (otherwise you could not see trends when training begins). If data does not stabilize (i.e. fluctuate only between 10-20%) within 7 sessions, the program may need to be revised.

11. Training Procedures: This section should specify what the trainer will do to teach the student to perform the behavior. Its greatest difference from baseline is the shaping or prompting prior to a trial, or the correction that may follow an incorrect or incomplete trial. To determine procedures for training the skill, consider the following:

a) Again, what cue(s) will be used to set the occasion for the behavior to occur?

b) What is the trainer to accept as a correct response? (If using a chaining procedure, specify what is accepted for each step of training.)

c) What consequence is given to the student for a correct response?

d) How is a correct response recorded on the data sheet?

e) If an incorrect response occurs, what should the trainer do? (correction, shaping, prompt)

f) How should the procedure for an incorrect response be noted on the data sheet?

g) How many trials are to be presented in each session?

12. Task Analysis: When the program to be trained could most effectively be taught using a chaining or total cycle procedure, it will be necessary to analyze the skill. This requires a careful look at each component that comprises the behavior. There are two ways to analyze a task. One method is labeled 'logical' and involves performing the task yourself and writing down each step as it's completed. Using the second method, 'empirical', the individual observes a variety of others doing the task and devises the steps from these observations.

Does the training procedure developed here require a chaining or total cycle (i.e. training all steps) procedure?

If so, what steps are necessary for the student to perform in order to complete the behavior?

If not, (i.e. a procedural or shaping procedure is being used), note that this section is 'not applicable.'

13. Criteria: How well must the student do to graduate from the program, and, if applicable, how well must he/she do to move from one step of the task analysis to the other?

14. Charting: (Explain how the graphs will be kept, e.g. what information will be pictured.)

15. Recommended Next Program: (Specify what skills would be appropriate to train after this skill is learned. This will assure a cohesive curriculum for the student.)

ASSIGNMENT 20

Prerequisite Readings: Assignments 18 and 19

Assignment: Develop a data sheet to record each behavior. Use the data sheet provided in Assignment 16 as an example. Include all components listed on the next page.

Rationale: Experience in designing data sheets when teaching a two behavior skill cluster.

Criteria:
1) 100% correct labeling and format
2) Usability of data form.

(One try, however revisions will be required until criterion is met.)

Special Instructions: This assignment must be approved before Assignment 22 is begun.

COMPONENTS OF A DATA SHEET

1. Program title
2. Trainer's name
3. Student's name
4. Date
5. Whether session is baseline, training, or probe
6. Session number
7. The time the session took
8. Behavioral definitions of the response(s) being recorded
9. The reinforcer used
10. The name of the primary observer
11. The name of the reliability observer (if any)
12. A place to put data for each trial
13. Summary score(s)
14. Reliability quotient (if any)
15. Scoring method

ASSIGNMENT 21

Prerequisite Readings: Assignments 18, 19 and 20

Assignment: Design as many graphs as necessary to show progress for each skill programming. Use graphs provided in Assign an example. Include all components required on Graph Design Checklist.

Rationale: Experience in designing graphs to picture student progress in programming.

Criteria: 100% correct placement of graph components and 100% correct placement of data points. (Two tries, with feedback given following the first effort.)

GRAPH DESIGN CHECKLIST

☐ Name of Program

☐ Skill(s) taught

☐ Student's Name

☐ Trainer's Name

☐ Reinforcer

☐ Label baseline

☐ Label training

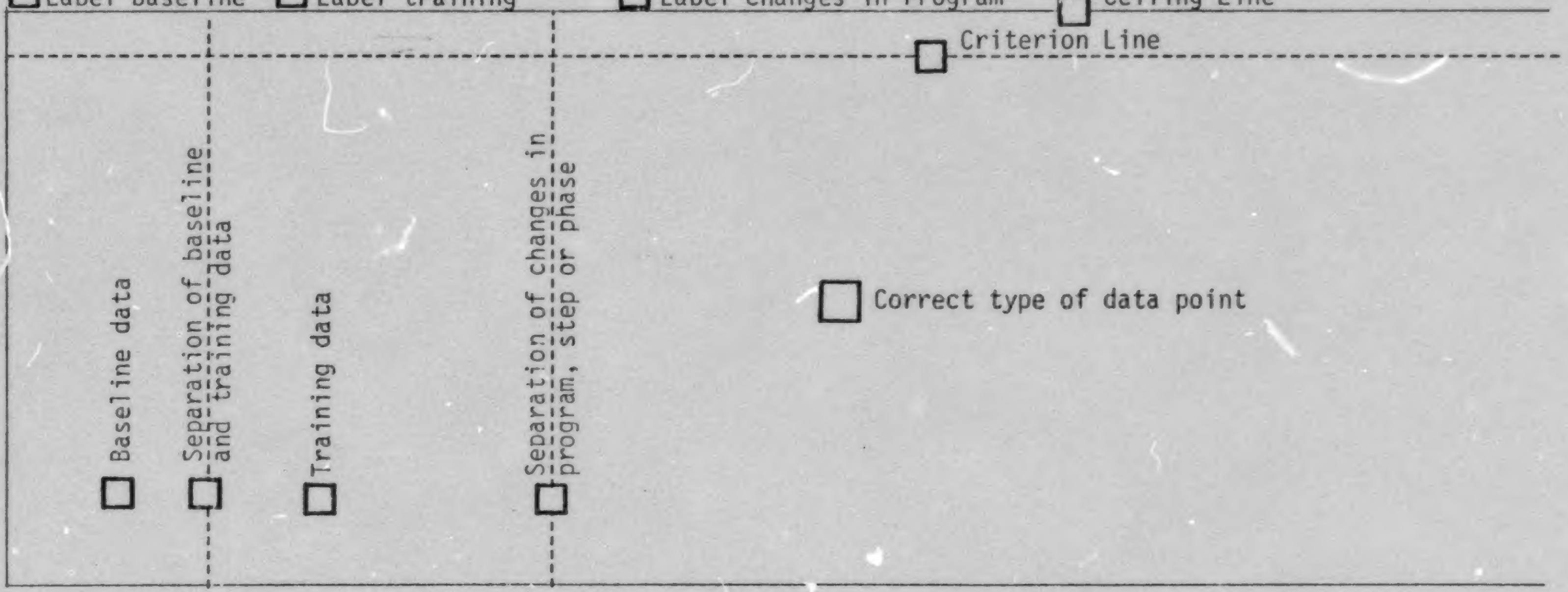
☐ Label changes in Program

☐ Ceiling Line

☐ Criterion Line

☐ Label ordinate (i.e. percentage of...; correct number of...)

☐ Identify ordinate measurement



☐ Baseline data

☐ Separation of baseline and training data

☐ Training data

☐ Separation of changes in program, step or phase

☐ Correct type of data point

☐ Identify abscissa measurement

☐ Label abscissa

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ASSIGNMENT 22

Prerequisite Readings: Modules 2 and 3

Assignment: Implement the baseline and training for programs developed in Assignment 19.

Rationale: Experience in implementation of instructional programming.

Criteria: This assignment will be graded concurrently with Assignment 23.

ASSIGNMENT 23

Prerequisite Reading: Program Review Form and explanation sheet

Assignment: Following the first two weeks of data collection for the programs developed in Assignment 19, complete a Program Review Form for each program.

Rationale: Experience in implementation and evaluation of instructional programming.

Criteria: 100% correct completion of Program Review Form for each program. (Two tries, revisions will be required until criterion is met.)

Special Instructions: When submitting this assignment, attach one copy of the data sheet and a copy of each graph for the programs implemented.

PROGRAM REVIEW FORM

Student:

Program:

Step #:

Trainer(s):

Reinforcer:

Date:

Program Summary

	Accelerating	Decelerating	Maintaining
Program Plan:	☐	☐	☐
Program is:	☐	☐	☐

Possible Program Changes: (List at least 3)

1.
2.
3.

Program Decision

Chosen Program Change: #

Date Implemented:

☐ Recorded in STEP

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HOW TO FILL OUT THE Program Review Form

Student: Name of the student in the program. If it is a group program, each student should have a separate Program Review.

Program: Name of the program that is being reviewed. If there is a cluster of programs being taught together, each program must be reviewed separately.

Step #: The step that the student is working on at the time that the program is being reviewed, e.g. baseline, Step 1, Step 2.

Trainer(s): The name of the trainer(s) that run the program.

Reinforcer: What reinforcer is being used with the student at the time of this review; e.g. social, hugs, juice, raisens.

Date: The date that the Program Review is filled out.

Program Summary

Program Plan: Describe the goal of the program. For example, is the data supposed to accelerate (increase), decelerate (decrease), or maintain (stay the same)?

Program is: Describe the present trend of the data. For example, is the data accelerating (increasing), decelerating (decreasing), or maintaining (staying the same or bouncing)?

Possible Program Changes

This section needs to be filled out only if there is a discrepancy in the "Program Plan" and the "Program is." If this is the situation, the teacher should list at least three (3) possible modifications that would be approprite to the program, e.g. change reinforcer, change cue.

Program Decision: This section is to be filled out only if program changes are necessary.

Chosen Program Change: The teacher (or team) must decide which one of the 3 Possible Program Changes to implement. Only one should be chosen.

Date Implemented: The actual date that the program change is to be implemented in the classroom.

☐ Recorded in STEP: The Program Monitoring card in the STEP File (or an equivalent) that corresponds to this program should be up-dated. If a program change is to be implemented, this change should be indicated; if no change was necessary, the date of the review should be recorded to indicate that the program was reviewed.

ASSIGNMENT 24

Prerequisite Reading: Module 3

Assignment: Develop a record keeping system with all the required components of a STEP file for 2 students in the classroom. (We recommend the student you are currently working with, and a physically handicapped or student with a behavior problem. This will help you in intermediate practicum.)

Rationale: Written records are an integral part of the classroom development. The STEP file provides a quick and easy method for compiling such information.

Criteria: This will be graded as complete/incomplete. However, the file will also be required in intermediate and advanced practicum.

Special Instructions: The file need not be on index cards as diagrammed. Any method for collecting the required information is acceptable (notebook, folder, etc.). Additional information may be included if it is appropriate for your classroom.

REVISED
DEC 80

INTERMEDIATE PRACTICUM

(Module 15)

Revised by:

Lesley Fernandez, Fredda Brown, Gayle Yelenik, Jennifer Holvoet, Pat Welch & Doug Guess

Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped
The University of Kansas Department of Special Education

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Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped
The University of Kansas Department of Special Education
Competency Specifications for:

INTERMEDIATE CLASSROOM PARTICIPATION MODULE

EDUCATIONAL GOAL

To provide experiences in active interaction with special education teachers and severely handicapped persons in special classrooms located in public schools and residential settings and to teach the application of information obtained from the Kansas University special education course, 798, Advanced Topics in Special Education, SMH.

PERFORMANCE COMPETANCIES

The student teacher completing this module should apply the information acquired from the modular readings and/or lecture courses by:

1. Using at least three different systems for measuring responses such as (a) outcome recording, (b) event recording, (c) interval recording, (d) time-sample recording, (e) rate recording, and (f) duration recording.
2. Selecting the measurement system that is most appropriate for the target behavior.
3. Developing an ICS for a SMH student who demonstrates behavioral deviancy.
4. Writing programs to teach specific age-appropriate functional skills to SMH students who are behaviorally deviant and physically handicapped.
5. Implementing programs which teach specific, age-appropriate functional skills to SMH students.
6. Writing a program which utilizes a specific technique to decelerate a specific behavior using response cost, extinction or overcorrection.
7. Submitting deceleration programs to parents and other staff for safeguard review.
8. Implementing the approved deceleration procedure to decrease a specific behavior.
9. Implementing a procedure which ensures differential reinforcement of other and/or incompatible behavior to decrease the rate of the behavior identified above.

10. Designing, labeling and correctly utilizing data sheets for teaching sequences (skill clusters).

11. Designing, labeling and correctly plotting data points on a standard graph (equal interval) to display student performance in baseline and training.

12. Designing, labeling and correctly plotting data points on a 6-cycle log chart to display student performance in baseline and training.

13. Determining from baseline data when to implement a training procedure.

14. Determining the effectiveness of training procedures by comparing data in training condition(s) to data in baseline condition.

15. Designing and implementing staff meetings to get feedback on the student's new programs.

16. Identifying the specific motor problems demonstrated by a student and facilitative positions which would help alleviate some of this students problems.

17. Writing a program which utilizes a specific technique to teach a physically handicapped individual to eat or drink more easily.

18. Writing a program which utilizes a specific technique (and perhaps prosthetics) to teach a physically handicapped student to communicate.

19. Demonstrating techniques for moving the limbs, trunk, and head when positioning or transferring individuals with severe motor handicaps.

20. Implementing a 4-part teaching sequence with a physically involved individual.

21. Demonstrating correct positioning and handling during educational programming of individuals with severe motor handicaps.

22. Maintaining up-to-date and accurate records on program changes and program progress (STEP).

23. Designing a set of teaching sequences for a two student group.

24. Demonstrating ability to utilize prosthetic devices such as hearing aids, adapted wheelchairs, and braces.

STUDENT GRADE SHEET Intermediate Practicum

Practicum Supervisor: ______________________________

Assignment 1:	Acceptable	Not Acceptable				
Assignment 2.1:	A	B	C	D	F	
2.2	Midsemester check	A	B	C	D	F
	Final check	A	B	C	D	F
Assignment 3.1	Acceptable	Not Acceptable				
3.2	A	B	C	D	F	
Assignment 4a	1st try	A	B	C	D	F
	2nd try	A	B	C	D	F
4b	1st try	A	B	C	D	F
	2nd try	A	B	C	D	F
4c	1st try	A	B	C	D	F
	2nd try	A	B	C	D	F
Assignment 5.1	1st try	A	B	C	D	F
	2nd try	A	B	C	D	F
5.2a	1st try	A	B	C	D	F
	2nd try	A	B	C	D	F
5.2b	1st try	A	B	C	D	F
	2nd try	A	B	C	D	F
5.2c	1st try	A	B	C	D	F
	2nd try	A	B	C	D	F
Assignment 6.1	A	B	C	D	F	
6.2	Acceptable	Not Acceptable				
Assignment 7.1	Acceptable	Not Acceptable				
7.2	Acceptable	Not Acceptable				
7.3	A	B	C	D	F	
Assignment 8.1a	A	B	C	D	F	
8.1b	A	B	C	D	F	
8.2a	A	B	C	D	F	
8.2b	A	B	C	D	F	
8.2c	A	B	C	D	F	

Assignment	8.3a	First try	A	B	C	D	F	
		Second try	A	B	C	D	F	
	8.3b	A	B		C		D	F
Assignment	9a	1st try	A	B	C	D	F	
		2nd try	A	B	C	D	F	
	9b		A	B	C	D	F	
Assignment	10.1	Acceptable	Not Acceptable					
	10.2	A	B		C		D	F
Assignment	11a	A	B		C		D	F
	11b	A	B		C		D	F
	11c	A	B		C		D	F
	11d	A	B		C		D	F
Assignment	12.1	A	B		C		D	F
	12.2a	A	B		C		D	F
	12.2b	A	B		C		D	F
	12.2c	A	B		C		D	F
	12.2d	A	B		C		D	F
Assignment	13.1	A	B		C		D	F
	13.2	Acceptable	Not Acceptable					
Assignemtn	14.1	A	B		C		D	F
	14.2a	A	B		C		D	F
	14.2b	A	B		C		D	F
Assignment	15.1	Lift _____	Acceptable		Not Acceptable			
		Lift _____	Acceptable		Not Acceptable			
	15.2a	N/A	Acceptable		Not Acceptable			
	15.2b	N/A	Acceptable		Not Acceptable			
	15.2c	N/A	Acceptable		Not Acceptable			
	15.2d	N/A	Acceptable		Not Acceptable			
		F (Incorrect implementation endangered student)						
Assignment	16.1	A	B		C		D	F
	16.2	A	B		C		D	F
	16.3	A	B		C		D	F

ASSIGNMENT 1 Week 1

Prerequisite Readings: None

Assignment:

1. Write a 1-3 page description of an ideal classroom incorporating your own ideas and any suggestions from the modules which you have particularly liked.

Rationale:

This is part of an overall evaluation for the modules.

Criteria & Grading:

One try

It will be graded Acceptable/Not Acceptable

ASSIGNMENT 2

Prerequisite Readings: Module 3 (STEP)

Assignment:

2.1 Identify one student who exhibits a behavior which needs to be decelerated. Turn in a written list of present objectives and future objectives for this student.

2.2 Begin developing a STEP file (or it's equivalent; see pages 3 and 4 for necessary components) on 4 students in your classroom; one student who has a behavior which needs to be decelerated, one student who is physically handicapped or a problem eater, and two students who may be programmed in a group.

Rationale:

Written records are an integral part of classroom development. The STEP file provides a quick and easy method for compiling such information.

Criteria:

2.1 The student who has been identified for the deceleration program must have at least 2 objectives in each of the following domains: self-help/daily living; communication; prevocation/vocational; preacademic/academic; fine/gross motor; socialization; and leisure, a minimum of 14 objectives per student. These objectives need not all be ongoing, some of them can be future objectives.

2.2 All components of the file must be present as delineated in the STEP file check. Your supervisor will check the file (identified in assignment 2.1) midway through the semester and at the end of the semester. The other 3 student's files will be checked during the second half of the semester.

One try, however, revisions will be required until 90% criteria is met.

Special Instructions:

The file need not be on index cards as diagrammed in the module. Any method for collecting the required information is acceptable (notebook, folder, etc.). Additional information may be included if it is appropriate for your classroom. If a section is not applicable to a particular student (for example, transfers may not be applicable for an ambulatory student), indicate that this information is non-applicable.

STEP FILE
CHECK

I. Cover Information

- A. Student's full name
- B. Birthdate
- C. Parents name
- D. Parent's address
- E. Parent's telephone number
- F. Student's residence
- G. Emergency contact and phone number
- H. Doctor's name and phone number
- I. Preferred hospital
- J Current education placement

II. Precautionary Information

- A. Health
  - 1. Allergies
  - 2. Immunizations (what/date)
  - 3. Handicaps
- B. Medications
  - 1. Medication name
  - 2. Amount
  - 3. Start date
  - 4. Stop date
- C. Danger
  - 1. Behavior problems
  - 2. Orthopedic precautions

III. Orthopedic

- A. Positioning
  - 1. Beneficial positions
  - 2. Transfers
  - 3. Carries
- B. Adaptive Equipment/Materials
  - 1. Date equipment use began
  - 2. Equipment/material, ie. arm sling, built-up spoon, etc.
  - 3. Program/time, ie. mealtime, hairbrushing, etc.

IV. Standardized Test Data

- A. Date test given
- B. Name of test and score

V. Educational Objectives
- A. Objective
- B. Curricular domain of objective, ie. fine motor, self-help, etc.
- C. Priority level of objective, ie. high priority, future objective, etc.
- D. Current status of objective, ie. ongoing, not implemented, on hold, etc.

STEP file (cont.)

VI. Program Implementation

- A. Ongoing programs
    - 1. Title of program
    - 2. Behavioral objective
    - 3. Overview of program
        - a. Definition of response
        - b. Correction procedure
        - c. Data taking, ie. +, -; 2,1,0; etc.
        - d. Criterion
- B. Program monitoring
    - 1. Program and data reviews
    - 2. Subsequent decision making

ASSIGNMENT 3

Week 2

Prerequisite Readings: Modules 10, 11 and 3

Assignment:

1. List three programs(either current or newly developed) which can be taught together as a teaching sequence (skill cluster). These programs must include:
   - A. A deceleration program for the inappropriate behavior.*
   - B. A behavior which is incompatible with the inappropriate behavior.
   - C. Any other program, preferably some type of imitation training.
2. Describe why these programs form a teaching sequence, give a rationale for your choice of deceleration technique, and list the sequence in which the behaviors would be taught.

Rationale:

Practice in devising training sequences for individuals with inappropriate behavior.

Criteria & Grading:

3.1 Acceptable/Unacceptable.

3.2 One try, however revisions will be required until all components are present.

The following will be considered when grading: functionality of program, age-appropriateness (if relevant), and cohesiveness of the programs chosen.

Special Instructions:

* Some examples of deceleration programs are: extinction, positive practice overcorrection, restitutional overcorrection, response cost and/or DRO.

DO NOT begin Assignment 4 until supervisor has approved Assignment 3.

ASSIGNMENT 4 Weeks 3 & 4

Prerequisite Readings: Modules 10, 11, 6(Program Format section), & 7 (types of measurement)

Assignment:

1. For each of the three programs listed in Assignment 3, turn in a written program using format outlined on next page. The following must be components of these programs.

   A. At least one program must use event recording.

   B. At least one program must use a time-based (e.g. interval, duration, etc.) recording

   C. At least one program must use rate measurement as it will be plotted on 6-cycle logarithmic charts.

Rationale:

Application of information on measurement design and program design.

Criteria & Grading:

Each program will be graded separately (see Program Format on next page). Two tries on each program, however revision required until 95% criteria is reached.

The following will be considered when grading: functionality and age-appropriateness of materials, proper format, program design (does it look like it will work), appropriateness of measurement system to the program, and compatibility of the design with the other programs which will be run in the teaching sequence.*

Special Instructions:

*You may find that your choices of programs will have to change from Assignment 3 if the programs chosen do not lend themselves to the types of measurement techniques assigned. If this is the case, choose a new program(s).

Turn in concurrently with Assignment 5.

PROGRAM FORMAT

Title of Program

Author

Person Responsible

Objective: include cues, behavior and criteria

Rationale

Functional scheduling

Materials

Cue: Include verbal/signed cues, objects or materials presented to the student and position of student/trainer.

Data Recording Statement: Consistent with the procedures outlined in the training section and describing how to score correct/incorrect responses.

Baseline: Include what cues were used to elicit the response, what the trainer accepts as a correct response, how the trainer consequates a correct/incorrect/no response, what the trainer does if the student responds incorrectly, data used, how many sessions (baseline) are run, and how many trials constitute a session.

Training Procedures: Include what cues were used to elicit the response, what a correct response is, how correct/incorrect/no response trials are consequated, how correct/incorrect/no responses are recorded on the data sheet, and how many trials are presented in 1 session.

Task Analysis

Criteria: Include latency, aim, and time element criteria for changing program steps and graduating from the program.

Charting: Include what graphs will be used and how they will be labeled.

How Reinforcement Will be Faded

Next Recommended Program

Weeks 3 & 4

ASSIGNMENT 5

Prerequisite Readings: Module 7 & 15

Assignment:

1. Design one ICS data sheet for the three programmed behaviors.*
2. Design as many graphs as necessary. One graph must be 6-cycle logarithmic.

Rationale:

Application of techniques for designing data sheets for teaching sequences and design of graphs.

Supervisor:

Will provide 6-cycle log charts.

Criteria & Grading:

The graphs and data sheets will be graded separately. Two tries on each, however, revisions will be required until all components are present. The following will be considered when grading: Correct labeling and format on the data sheet, usability of data sheet, correct format of graphs (see graph design checklists enclosed in this module), accurate recording of any data from previous training on this program.**

Special Instructions:

*When doing deceleration programs, the deceleration program will only be listed at the end of a series of skill clusters, where a total will be recorded. The deceleration technique should be applied each time the deviant behavior occurs and a count of how often it was applied in the session kept. However, within each skill cluster there should be a trial called "Behavior check". This trial will be where the student will be given reinforcement for not engaging in the deviant behavior (i.e. all programs used in this practicum will have a DRO component.)

** If you have more than one month's data, you may summarize by recording all baseline data and weekly training averages.

ASSIGNMENT 6 Week 5

Prerequisite Readings: None

Assignments:

1. Make an outline of a staff meeting in which you will describe your three-part teaching sequence to other members of the staff.
2. Implement the staff meeting with at least one aide (or psychologist, or head teacher). Also try to have your building supervisor attend the meeting.

Rationale:

Practice in developing and being responsible for staff meetings in which information about a student's program is communicated to others in the classroom.

Criteria & Grading

One try

The following will be considered when grading:

a. Reasonable outline containing the following: purpose of meeting, rationale for the sequence, individual training methods (shaping, DRO, etc.). Data strategies, materials that will be brought to the meeting, and what kind of input/cooperation will be expected from the staff.

b. Statement by given person that you held the meeting and that person's ability to answer 1-2 questions about that student's programs.

Supervisor will attend staff meeting if possible.

ASSIGNMENT 7 Week 6

Prerequisite Readings: Your facility's policy on the use of deceleration techniques (You find it!)

Assignment:

1. Copy or describe the procedures (if any) which your facility uses to safeguard students who are in deceleration programs (e.g. committee review).

2. Begin implementing these procedures by following the recommended facility policy. Such procedures generally take 1-2 months to complete, so don't delay. If some type of committee review is not required, either because of the procedure chosen or because the facility has no policy), draft a letter describing your procedure and have your building (or program) supervisor sign it.

3. Draft a parent (or guardian) letter describing your procedures and asking permission. Mail it (if policy requires parental permission).*

Rationale:

Practice in correct and lawful use of deceleration procedures includes implementing all procedures which the facility has devised to safeguard the student's well-being.

Criteria & Grading:

7.1 and 7.2 Procedures and the implementation will be graded Acceptable/ Not acceptable.

7.3 The following will be considered when grading the parent letter: grammar, tact, a concise and understandable explanation of the procedure and how it interfered in the classroom, a rationale for the procedure, the presence of a form which the parents can sign, the statement that parents will be welcome to come and watch the procedure or to discuss any changes they feel need to be made, a statement that you will send them the data on the program if they so desire, and a statement that welcomes the parents as team members.

One try, however revisions will be required until all components of the parent letter are present.

Special Instructions:

DO NOT MAIL PARENT LETTER UNTIL SUPERVISOR HAS APPROVED IT!

ASSIGNMENT 8

Week 7 (continue until
criterion is reached)

Prerequisite Readings: Modules 7, 8, 10, and 11

Assignment:

8.1 If awaiting approval of the deceleration program, begin implementing the two other programs. Remember to take baseline if you haven't done so already. Begin deceleration program whenever approval is obtained. If review procedures were not necessary, begin implementing the three-part sequence.

Record data and graph the results, continuing training until the student reaches criterion or until the semester ends.

8.2 Turn in copies of graphs.

8.3 Turn in copies of Program Review Forms every month on each program.

Rationale:

Implementation, under supervision, of a three skill teaching sequence and correct implementation of the chosen deceleration technique.

Criteria & Grading:

8.1 a & b. Your supervisor will observe your sequence twice during the semester using a TPC 1 (example at back of module). Two tries on first observation, one try on second. Criteria is 90-100% on TPC.

8.2 a, b & c. Graphs must contain all necessary components (see graph checklist).

8.3 a & b. A minimum of two program review forms per program. The program status and plan must be correctly identified and all components of the review form filled in. Two tries on first program review. One try on second program review.

Special Instructions;

Begin Assignment 9 immediately. DO NOT wait until you have completed all components of this assignment.

ASSIGNMENT 9 Week 8

Prerequisite Readings: Module 13. You may also utilize your OT/PT as a resource.

Assignment:

9.a Using the following pages as a guide, identify and describe in detail (using technical terms) one student who is physically handicapped. If you have a number of students to choose from, choose one who is a problem to feed.

9.b Turn in a written list of ongoing and future objectives for this student.

Rationale:

In order to effectively program for a physically handicapped student, it is necessary to know what his/her limitations and strengths are.

Criteria & Grading:

9a Two tries. Your description must include identification of: non-verbal mode of communication; best means of locomotion; best positions for carrying, standing, sitting and floor lying; appropriate tranfers; student's muscle tone; how often positions should be changed and movement interrelations (ATNR etc.). 90% criteria.

9b Must include 2 functional objectives in each of the following domains: self-help/daily living, communication, socialization, leisure, vocational/prevocational, academic/preacademic, and gross/fine motor.

Be sure to indicate which objectives are presently ongoing and which ones are objectives that are not yet in progress.

Initial Observation Exercise

1. Attempt to discern how your student communicates nonverbally. Observe how he/she uses, for example, his/her lips, eyebrows. eyes, head gesture, hands, body posture and noises to communicate.

2. If possible, observe your assigned student in both prone and supine positions. In each position notice configuration and position of the:

   a. head
   b. eyes
   c. neck
   d. shoulders
   e. upper arm (L and R)
   f. forearm (L and R)
   g. wrist (L and R)
   h. fingers
   i. thumbs
   j. trunk
   k. pelvis
   l. upper leg (L and R)
   m. lower leg (L and R)
   N. ankle (L and R)
   o. toes

3. Notice the interrelation between body parts when they are moved. For example, what happens to the shoulders, arms and legs when the head is moved?

4. If possible, and under the supervision of staff, gently handle the student's arms or legs and notice the muscle tone.

5. Attempt to mimic the posture or configuration of your student in both the prone and supine positions.

6. Draw the configuration of your student's body in prone and supine position. If you are not artistic, use stick drawings.

7. Using the module and pages 32-50 of Finnie's book attempt to find conditions which describe your student.

Adapted from: Training modules for teacher of SMH. University of Vermont, 1978

ASSESSMENT
OF
POSTURING / POSITIONING SKILLS

The Early On Program

IDENTIFICATION DATA

Child ______________________

Birthdate ______________________

Chronological Age ______________________

Date of Initial Assessment ______________________

Recording Procedures: Record notes and illustrations for each of the questions while receiving demonstration from informed consultant.

Question	Comments

What is the best position for carrying? ______________________

____

What is the best means for locomotion for this child?

Rolling ______________________

Tummy Crawling ______________________

Creeping (all fours) ______________________

Cruising ______________________

Walking ______________________

Wheelchair ______________________

Scooter Board ______________________

What is the best standing position for this child?

Standing Table ______________________

Prone Board ______________________

____

____

What is the best sitting position? What special equipment is necessary? Where should supports be provided? At what angle should the child be seated?

Armless Chair ______________________

Bench ______________________

C.P. Chair ______________________

Wheelchair ______________________

T Stool ______________________

Bean Bag Chair ______________________

Corner Chair ______________________

Side Sitting on Floor ______________________

Long Sitting ______________________

Indian Style Sitting ______________________

____

____

What is the best way for the child to assume a standing position?

From floor? ______________________

From chair? ______________________

____

____

____

____

Question **Comments**

What is the best position for floor lying? In prone? In supine?

With support? Where?

Over bolster at chest? Additional support needed? Where?

Over wedge? Additional supports needed? Where?

Side Lying? Additional Support needed? Where?

How frequently should positions be changed?

What are some critical do's and don'ts?

Illustrations

ASSIGNMENT 10

Week 9

Prerequisite Readings: Modules 13 & 14

Assignment:

1. For the student described in Assignment 9, list four (4) programs, current or newly developed, which can be taught together as a teaching sequence (skill cluster). These programs must include:

   A. A program to teach receptive communication

   B. A program to teach expressive communication

   C. A feeding and/or drinking program**

   D. One other program of your choice

2. Describe why these programs form a teaching sequence, any adaptive equipment which will be needed, and list the sequence in which the behaviors will be taught.

Rationale:

Practice in devising training sequences for individuals with physical handicaps.

Critria & Grading:

One try, however revisions will be required.

The following will be considered when grading: Discussion of functionality of programs, age-appropriateness, consideration of least restrictive alternatives especially if adaptive equipment is needed, cohesiveness of the programs chosen, and appropriate communication mode.

Special Instructions:

---

*If no student in you class needs feeding and drinking training (due to a physical handicap), please substitute a mobility program. If this is still impossible, please contact your practicum supervisor.

ASSIGNMENT 11 Week 10 & 11

Prerequisite Readings: Modules 6, 10, 13, (maybe 14, if using adaptive equipment).

Assignment:

1. For each of the four programs listed in Assignment 10, turn in a written program using format outlined on page 17a. At least two different types of measurement must be used in this assignment.

Rationale:

Practice in program writing and use of measurement systems.

Criteria & Grading:

See program format on page 17a.

The following will be considered when grading: specification of proper positioning (be sure this is compatible for all programs run in the teaching sequence), functionality and age-appropriateness of materials, correct format, program design (does it look like it would work).

One try, however revisions will be required until 90% criteria is reached.

Special Instructions:

Don't forget to solicit imput from O.T., P.T., and/or Speech therapists if needed.

Turn in concurrently with Assignment 12.

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Program Components

Title of program

Author

Person Responsible

Objective statement including cues, behavior and criteria.

Rationale

Functional scheduling

Materials

Cue statement including verbal/signed cues, objects or materials presented to the student and position of student/trainer.

Data recording statement that is consistent with the procedures outlined in the Training section and describes how to score correct/incorrect responses.

Baseline section including what cues were used to elicit the response, what the trainer accepts as a correct response, how the trainer consequates a correct/incorrect/no response, what the trainer does if the student responds incorrectly, data used, how many sessions (baseline) are run, and how many trials constitute a session.

Training procedures section including what cues were used to elicit the response, what a correct response is, how correct/incorrect/no response trials are consequated, how correct/incorrect/no responses are recorded on the data sheet, and how many trials are presented in 1 session.

Task Analysis

Criteria session including latency, aim, and time element criteria for changing program steps and graduating from the program.

Charting section including what graphs will be used and how they will be labeled. (This section is optional Fall 1980 semester, required Spring 1981 semester).

How Reinforcement will be faded

Next Recommended Program

ASSIGNMENT 12 Week 10 & 11

Prerequisite Readings: Modules 7 & 15

Assignment:

1. Design one ICS data sheet for the four programmed behaviors.
2. Design as many graphs as necessary.

Rationale:

Application of techniques for designing data sheets for longer teaching sequences and design of graphs.

Criteria & Grading:

One try

The following will be considered when grading: Appropriateness of the measurement system chosen, correct format of data sheet, usability of data sheet, correct format of graphs, (see Graph Design Checklist), accurate recording of any data from previous training on same program.*

Special Instructions:

*If you have more than one month's data, you may summarize by recording all baseline data and weekly training averages.

Prerequisite Readings: None

Assignment:

1. Using the pages provided with Assignment 6, make an outline of a staff meeting in which you will describe your four-part teaching sequence to other members of the staff.

2. Implement this staffing with at least one aide and one of the following: O.T., P.T., or Speech Therapist.

Rationale:

Practice in developing and being responsible for staff meetings with ancillary personnel from other departments present, to determine the most effective program possible.

Supervisor:

Should make every effort to attend this staffing, so other's input can be utilized in program design. However, if timing is not compatible with the schedule of others who should attend, this is optional.

Criteria & Grading:

One try

The following will be considered when grading:

a. Reasonable outline containing the following: purpose of meeting, rationale for the sequence, individual training methods (shaping, DRO, etc.). Data strategies, materials that will be brought to the meeting, and what kind of input/cooperation will be expected from the staff.

b. Statement by given person that you held the meeting and that person's ability to answer 1-2 questions about that student's programs.

Supervisor will attend staff meeting if possible.

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ASSIGNMENT 14

Week 13 (Continue until criterion is reached)

Prerequisite Readings: Modules 13 & 14 (You may also utilize your O.T./P.T as a resource.)

Assignment:

1. Implement the 4-part teaching sequence. Record data and graph the results.
2. Turn in copies of graphs and Program Review Forms every month on each program.

Rationale:

Practice under supervision implementing a four-part teaching sequence with special attention to special techniques necessary for physically handicapped students.

Criteria & Grading:

One try, your supervisor will observe at least once during the semester.

The following will be considered when grading: correct determination of when to begin training; correct handling, transfer, and positioning of student prior to, during, and after programming; correct facilitation of eating/drinking with proper lip/jaw control as needed, accurate data-taking (90-100% reliable); accurate graphing, and correct dtermination of training effectiveness with program changes based on data.

Special Instructions:

AN AUTOMATIC "F" WILL BE RECORDED IF INCORRECT IMPLEMENTATION OF ANY PROGRAM (ESPECIALLY FEEDING) ENDANGERS THE PHYSICAL WELL-BEING OF THE STUDENT. THIS "F" CANNOT BE ERASED DURING A SECOND TRY, ALTHOUGH YOU WILL BE REQUIRED TO CORRECT YOUR TECHNIQUE. To avoid such a situation, read your module(s) carefully, and get help from O.T. or P.T. at any point where you are doubtful of your ability.

Assignment 15 Weeks 15 & 16

Prerequisite Readings: Modules 13 & 14 (You should also use your O.T./P.T. as a resource.)

Assignment:

1. Demonstrate competency in at least two (2) of the following:
    A. lifting and transferring student from wheelchair to toilet.
    B. lifting and transferring student from chair to wheelchair
    C. Correct coordination of two person lift with naive person
    D. lifting and transferring student from a mat (or floor) to a chair across the classroom.
2. Demonstrate all of the following which are applicable:
    A. Putting diapers on floppy or spastic student.
    B. Hearing aid; check and putting aid on student
    C. Putting on braces or corrective shoes
    D. Placement of student in modified wheelchair

Criteria & Grading:

One try

The following will be considered when grading: demonstration of control of key points when transferring; correct choice of lifts depending on student size and disability; correct coordination of two person lift; using your legs, not your back to lift; correct application of prosthetics/diapers--without twisting limbs; and with correct handling of limbs.

This should be observed by either your practicum supervisor or by your O.T. or P.T. If observed by either of the latter, have them fill out OT/PT observation sheet and sign it.

Special Instructions:

AN AUTOMATIC "F" WILL BE RECORDED IF INCORRECT IMPLEMENTATION OF ANY PROCEDURE ENDANGERS (OR COULD ENDANGER) THE PHYSICAL WELL-BEING OF THE STUDENT. THIS "F" CANNOT BE ERASED DURING A SECOND TRY, ALTHOUGH YOU WILL BE REQUIRED TO CORRECT YOUR TECHNIQUE.

GT/PT Observation Sheet

Teacher's Name:__________________________

Date of Observation:______________________

Place of Observation:____________________

Directions: The teacher must demonstrate two of the four lifts outlined in assignment 15.1. He/she should demonstrate all of assignment 15.2 which are applicable to his/her classroom. Use the following scoring code:

+ Teacher correctly implements
- Teacher incorrectly implements
n/a Non-applicable

Assignment 15.1-Lifts

	15.1a	15.1b	15.1c	15.1d
Teacher relaxes the student before lifting				
Teacher brings the student to a sitting position				
Teacher allows the student to do as much as possible of the lift				
Teacher talks with the student and encourages his/her help				
Teacher keeps the student's head in a midline position				
Teacher keeps his/her back straight-uses his/her legs for the lift				
Teacher supports the student at his/her neck				
Teacher supports the student at his/her shoulders				
Teacher supports the student at his/her spine				
Teacher supports the student at his/her pelvis				
Teacher chooses the correct lift for the student				
Teacher correctly coordinates the chosen lift				

Assignment 15.2

15.2a-Diapers	Teacher doesn't twist the student's limbs	
	Teacher protects the student when applying diaper pins	
	Teacher correctly applies diaper-not too tight, not too loose	

15.2b-Hearing Aid

Teacher checks that the aid is charged	
Teacher checks that the earmolds are clean	
Teacher checks that there is no feedback	
Teacher checks that the aid is turned on	
Teacher checks that the aid is at the correct amplication	
Teacher puts on hearing aid	
Teacher puts on harness	

15.2c-Braces/Corrective Shoes

Teacher checks inside of shoes for wrinkles/tears	
Teacher checks that the brace locks are easily opened	
Teacher checks that joints move easily	
Teacher checks that soles/heels are not worn	
Teacher does not force the student's foot into the shoe	
Teacher fastens all straps/fasteners	

15.2d-Modified Wheelchair

- Teacher supports the student when lifting him/her to chair ☐
- Teacher makes sure that hips are correctly placed ☐
- Teacher checks clothing to make sure it isn't wrinkled under/behind the student ☐
- Teacher fastens all straps/fasteners ☐

COMMENTS:

____
Signature of Observer

____
Position of Observer

ASSIGNMENT 16

Prerequisite Readings: Modules 3, 10, 11, 12 and 13

Assignment:

16.1 Identify two students who could be programmed as a small group and turn in a written list of ongoing and future objectives for each student.

16.2 Identify a two program skill cluster for each of the two students and describe why these programs form a teaching sequence.

16.3 Identify the structure and content (see Brown, Holvoet, Guess and Mulligan, Module 3) of the group, list the sequence in which the behaviors will be taught across the students (i.e. are you alternating students after each behavior, every other behavior, or after three trials of the teaching sequence), and identify environmental considerations such as student seating, arrangement of materials, when data is to be taken, and group reinforcement.

Rationale:

Practice in devising training sequences which can be used in a group.

Criteria & Grading:

The following will be considered when grading: Functionality, age-appropriateness of programs, and program cohesiveness (see Assignments 2 and 9).

One try

Note: You will not be responsible for implementing this group program during the practicum. However, the advance practicum focuses heavily on group training. This would be an excellent time to try it out and get feedback before a grade is contingent upon your performance.

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Department of Special Education, The University of Kansas

GRAPH DESIGN CHECKLIST I (Equal Interval Graphing)

Student Teacher ____________________ Date ____________

Graph Shows Correct Labeling for:

☐ Program name
☐ Skill area
☐ Student's name
☐ Trainer's name
☐ Reinforcer

Ordinate:

☐ Identified
☐ Labeled

Abscissa:

☐ Dated

Baseline:

☐ Labeled
☐ Changed to training at appropriate point

Training:

☐ Labeled
☐ Made changes at appropriate points
☐ Separated from baseline

Shows changes in Program:

☐ Labeled
☐ Separated from previous training

Graph Shows Correct Labeling and Placement of:

☐ Ceiling Line
☐ Criterion Line
☐ Data Points

Comments: ____
____
____

Date received ____________ Sent for revisions ____________

Date accepted ____________ GRADE ____________

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for Teachers of the Severely Multiply Handicapped
The University of Kansas Department of Special Education

GRAPH DESIGN CHECKLIST II

6 - cycle Logarithmic Charting

____________________ Student Teacher

____________________ Date

Graph Shows Correct Labeling for:

- ☐ Behavior
- ☐ Charter
- ☐ Label
- ☐ Counted
- ☐ Agency
- ☐ Dates (including year)

Baseline:

- ☐ Labeled
- ☐ Changed to training at appropriate point
- ☐ Phase change line

Training:

- ☐ Labeled
- ☐ Mode changes at appropriate points
- ☐ Phase change line(s) at appropriate points
- ☐ Separated from baseline

Shows Program Changes:

- ☐ Labeled
- ☐ Not Applicable
- ☐ Separated from previous training by phase change lines

Graph Shows Correct Labeling and Placement of:

- ☐ Ceiling line (if appropriate)
- ☐ Record floor (if appropriate)
- ☐ Ignored days (if appropriate)
- ☐ No chance days (if appropriate)
- ☐ Aim Star
- ☐ Data points
- ☐ Type of data point
- ☐ No-count days (if appropriate)

Comments: ____

____

____

Date received ____________ Sent for revisions ____________

Date accepted ____________ GRADE ______

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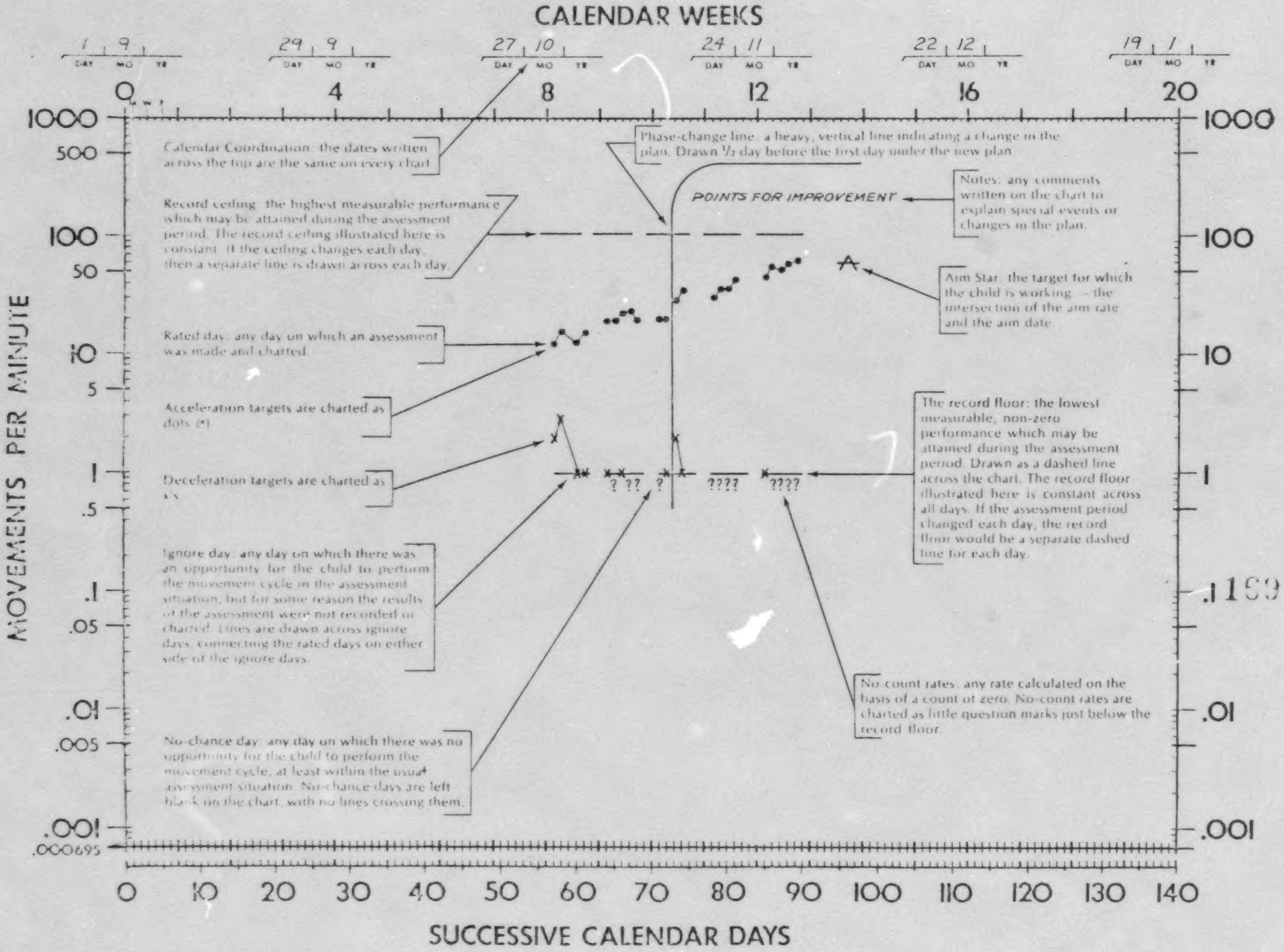
QUICK GUIDE 4 Charting Conventions



Calendar Coordination: the dates written across the top are the same on every chart

Record ceiling: the highest measurable performance which may be attained during the assessment period. The record ceiling illustrated here is constant. If the ceiling changes each day, then a separate line is drawn across each day.

Rated day: any day on which an assessment was made and charted.

Acceleration targets are charted as dots (•)

Deceleration targets are charted as x's.

Ignore day: any day on which there was an opportunity for the child to perform the movement cycle in the assessment situation, but for some reason the results of the assessment were not recorded or charted. Lines are drawn across ignore days, connecting the rated days on either side of the ignore days.

No-chance day: any day on which there was no opportunity for the child to perform the movement cycle, at least within the usual assessment situation. No-chance days are left blank on the chart, with no lines crossing them.

Phase-change line: a heavy, vertical line indicating a change in the plan. Drawn ½ day before the first day under the new plan

Notes: any comments written on the chart to explain special events or changes in the plan.

Aim Star: the target for which the child is working — the intersection of the aim rate and the aim date

The record floor: the lowest measurable, non-zero performance which may be attained during the assessment period. Drawn as a dashed line across the chart. The record floor illustrated here is constant across all days. If the assessment period changed each day, the record floor would be a separate dashed line for each day.

No-count rates: any rate calculated on the basis of a count of zero. No-count rates are charted as little question marks just below the record floor.

From: White, O. and Haring, N. Exceptional Teaching. Columbus, OH: Charles Merrill, 1976, p. 120.

PROGRAM REVIEW FORM

Student: ____________________

Program: ____________________

Step #: ____________________

Trainer(s): ____________________

Reinforcer: ____________________

Date: ____________

Program Summary

	Accelerating	Decelerating	Maintaining
Program Plan:	☐	☐	☐
Program is:	☐	☐	☐

Possible Program Changes: (List at least 3)

1.

2.

3.

Program Decision

Chosen Program Change: # ________

Date Implemented: ________

☐ Recorded in STEP

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HOW TO FILL OUT THE Program Review Form

Student: Name of the student in the program. If it is a group program, each student should have a separate Program Review.

Program: Name of the program that is being reviewed. If there is a cluster of programs being taught together, each program must be reviewed separately.

Step #: The step that the student is working on at the time that the program is being reviewed, e.g. baseline, Step 1, Step 2.

Trainer(s): The name of the trainer(s) that run the program.

Reinforcer: What reinforcer is being used with the student at the time of this review; e.g. social, hugs, juice, raisens.

Date: The date that the Program Review is filled out.

Program Summary

Program Plan: Describe the goal of the program. For example, is the data supposed to accelerate (increase), decelerate (decrease), or maintain (stay the same)?

Program is: Describe the present trend of the data. For example, is the data accelerating (increasing), decelerating (decreasing), or maintaining (staying the same or bouncing)?

Possible Program Changes

This section needs to be filled out only if there is a discrepancy in the "Program Plan" and the "Program is." If this is the situation, the teacher should list at least three (3) possible modifications that would be appropriate to the program, e.g. change reinforcer, change cue.

Program Decision: This section is to be filled out only if program changes are necessary.

Chosen Program Change: The teacher (or team) must decide which one of the 3 Possible Program Changes to implement. Only one should be chosen.

Date Implemented: The actual date that the program change is to be implemented in the classroom.

☐ Recorded in STEP: The Program Monitoring card in the STEP File (or an equivalent) that corresponds to this program should be up-dated. If a program change is to be implemented, this change should be indicated; if no change was necessary, the date of the review should be recorded to indicate that the program was reviewed.

TEACHING IMPLEMENTATION
OBSERVATION FORM
Adapted from The Early On Program

Student(s): ____________ Teacher ____________

Observer ____________

Date & Time ____________

Activities:

RECORDING PROCEDURES: *Observe teacher for 10-15 trials and record an X if behavior observed does not meet criteria listed on next page. Put NA or a line through nonapplicable sections. 80-100% is acceptable.*

Prior to conducting session trainer :

1. Has all required materials — Yes — No--List missing items, NA
2. Has complete programs and STEP in classroom — Yes — Yes, but ________, No
3. Seating arrangement appropriate — Yes — No--Tell why
4. Ss Adaptive equipment working/on — Yes — No (not avail) No (forgot), NA
5. Uses recommended reinforcer — Yes — No

During session, trainer	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
6. Attends to student behav.															
7. Materials															
A. Discriminable															
B. Positioned optimally															
C. Out of student's reach															
D. Within implementer's reach															
8. Cues (S^D's)															
A. Clear															
B. Correct wording															
C. Not repeated															
D. S positioned optimally															
9. Reinforcement: Indiv.															
A. For correct behavior															
B. Immediate															
C. Paired															
D. Schedule correct															
E. Appropriate intensity															
10. Reinforcement: Group															
11. Handles Inappropriates															
A. Interrupts incompatibles															
B. Implements correctly															
C. Correct schedule															
D. Immediate															
2. Correction Procedures															
A. Correct															
B. Immediate															
3. Data Recorded															

core after training session:

4. Pacing appropriate — Yes — No--state slow component
5. Trials alternated (within student) — Yes — No
6. Trials alternated (between students) — Yes — Yes, but ________, No, NA
7. DRO provided if deceleration used — Yes — No NA
8. Independent activities provided — Yes — Yes, but ________, No, NA
9. Interruptions handled — Yes — No NA
0. Summarizes data — Yes — Yes, but ________, No
1. Plots data — Yes — Yes, but ________, No

REVISED

JAN. '81

ADVANCED CLASSROOM PARTICIPATION

(Module 25)

Revised by:
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Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped
The University of Kansas Department of Special Education

Original by:
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Department of Special Education
The University of Kansas

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Severely Multiply Handicapped.

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Statewide Inservice Training Project for Teachers of the Severely Multiply Handicapped

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Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped
The University of Kansas Department of Special Education
Competency Specifications for:

ADVANCED CLASSROOM PARTICIPATION MODULE

EDUCATIONAL GOAL

To provide experiences in active interaction with special education teachers and severely handicapped children in special classrooms located in public schools and residential settings and to teach the application of information obtained from Modules 1-24.

PERFORMANCE COMPETENCIES

The student teacher completing this module should apply the information acquired from the modular readings and/or lecture courses by:

1. Designing classroom schedules and student schedules.
2. Outlining, implementing and heading two staff meetings to communicate schedule changes.
3. Developing a training model for the preparation of teaching assistants.
4. Effectively implementing new schedules of programming in the classroom.
5. Developing a format for the accountability and supervision of teaching assistants.
6. Compiling a listing of resources available for parents in the local community.
7. Developing a parent involvement program and obtaining administrative approval of the plan.
8. Arranging and implementing an IEP conference or parent conference.
9. Maintaining and updating the STEP file.
10. Describing an errorless discrimination training program.
11. Designing and managing group (3:1 or 4:1) programs using individual skill clusters (teaching sequences) for each individual in the group.

OVERVIEW*

*READ: This is essential information

In this practicum, you will be graded on five different activities, each of which may have as many as 4 assignments. It is difficult to arrange these in a chronological practicum because they need to be worked on simultaneously from the beginning of the practicum to the end. So, although the assignments appear to be chronological (they are written sequentially and each has a time line), you cannot wait until you have finished one activity to begin the next. The necessity for concurrent implementation makes the practicum difficult, both for you and your supervisor, but it's more realistic in terms of actually managing a classroom.

The areas of activities required for completion of this practicum are:

I. SCHEDULING: Assignments 1-3
II. STAFF TRAINING AND SCHEDULE IMPLEMENTATION: Assignments 4-6
III. PARENTAL INVOLVEMENT: Assignments 7-10
IV. GROUP PROGRAMMING: Assignments 11-17
V. 1:1 ERRORLESS STIMULUS CONTROL PROGRAMMING: Assignments 18-20

When scheduling yourself, REMEMBER, THESE AREAS SHOULD BE WORKED ON AT THE SAME TIME. It is especially important to begin the Group Programming Sequence promptly in order to leave plenty of time for running the programs and collecting the data.

It is also important for you to realize that although we will not always be assigning you to write programs, make graphs and data sheets, and do STEP file maintenance, it is assumed that you will do these things and you will be graded on whether or not these have been done and maintained. Your files will be checked twice during the semester (see Assignment #2), and general classroom management will also be evaluated twice during the semester (see Assignment #18). We feel that we can legitimately expect you to continue demonstrating skills you learned in the other practicums without specifically reassigning these skills. Thus, most assignments here are new skills that you have not practiced in previous practicums, but we do expect maintenance of skills from earlier practicums. NOTE: All assignments that are graded Acceptable/Not Acceptable, Complete/Not Complete, etc. must be revised until your supervisor considers it Acceptable/Complete.

GRADE SHEET FOR ADVANCED PROACTICUM ASSIGNMENTS

Assignment 1: Acceptable Not Acceptable

Assignment 2: 1) Acceptable Not Acceptabel

2)

	Midsemester				End Semester			
Student a	A	B	C	D	A	B	C	D
Student b	A	B	C	D	A	B	C	D
Student c	A	B	C	D	A	B	C	D
Student d	A	B	C	D	A	B	C	D
Student e	A	B	C	D	A	B	C	D
Student f	A	B	C	D	A	B	C	D
Student g	A	B	C	D	A	B	C	D

Assignment 3: 1) First try A B C
Second try A B C
2) Acceptable Not Acceptable
3) Acceptable Not Acceptable

Assignment 4: A B C

Assignment 5: 1) A B C
2) Acceptable Not Acceptable

Assignment 6: A B C

Assignment 7: 1) Complete Incomplete
2) Acceptable Not Acceptable

Assignment 8: 1) Complete Incomplete
2) Complete Incomplete

Assignment 9: 1) Acceptable Inappropriate
2) Accepted by program Not accepted

Assignment 10: Acceptable Not Acceptable

Assignment 11: 1) A B C
2) Acceptable Not Acceptable
3) A B C

Assignment 12: 1) a) A B C D F
b) A B C D F 1st try
c) A B C D F
d) A B C D F

Assignment 12 (Cont.)

2) A B C D F
3) a) A B C D F
b) A B C D F
c) A B C D F 1st try
d) A B C D F

Assignment 13: A B C D F 1st try
A B C D F 2nd try

Assignment 14: 1) A B C
2) Acceptable Not Acceptable
3) A B C

Assignment 15: 1) a) A B C D F
b) A B C D F
c) A B C D F
d) A B C D F
e) A B C D F
f) A B C D F
g) A B C D F
h) A B C D F
i) A B C D F
2) A B C D F

Assignment 15 (Cont.)

3) a) A B C D F
b) A B C D F
c) A B C D F
d) A B C D F
e) A B C D F
f) A B C D F
g) A B C D F
h) A B C D F
i) A B C D F

Assignment 16: A B C D F 1st try
A B C D F 2nd try

Assignment 17: Small group 1) A B C D F
2) A B C D F
Large group 1) A B C D F
2) A B C D F

Assignment 18:

	Midsemester					End Semester				
Student A:	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
Student B:	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
Student C:	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
Student D:	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
Student E:	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
Student F:	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F
	A	B	C	D	F	A	B	C	D	F

Assignment 19: Acceptable Not Acceptable

Assignment 20: A B C D F 1st try
A B C D F 2nd try

Assignment 21: Acceptable Not Acceptable

ASSIGNMENT 1

Prerequisite Readings: None

Assignment: Write a 1-3 page description of an ideal classroom incorporating your own ideas and any suggestions from the modules which you have particularly liked.

Rationale: This is part of an overall evaluation for the modules.

Criteria: One try. It will be graded Acceptable/Not turned in.

Special Instructions: Turn in concurrently with Assignment 2

ASSIGNMENT 2

Prerequisite Readings: Module 3 (STEP)

Assignment:
1. Make a list or copy of the programs each student is engaged in.
2. Be sure STEP files (or an equivalent) are up-to-date on all students in the classroom with whom you will be working.

Rationale: This serves as a check on the maintenance of the STEP file established in earlier practicums. It allows the supervisor to have a global view of the students' programs, thus helping him/her help the student teacher in devising reasonable group programs. It is a prerequisite to Assignment 3.

Criteria:
1. The list of programs will be graded acceptable/not turned in. Each student must have 2 objectives identified in each of the following domains: Self-help/daily living; communication; prevocational/vocational; preacademic/academic; fine/gross motor; socialization; leisure---a minimum of 14 objectives per student.
2. The STEP file will be examined (using the STEP Check) 2 times during the semester, once in the middle of the semester and again at the end of the semester.

Special Instructions: If you have changed practicum sites since the semester when you designed a STEP file and the new site does not have STEP files, turn in copies of IEPs or current programs and current graphs and begin a new STEP file for the students you will be working with in this practicum.

Turn this in concurrently with Assignment 3.

Assignment 3

Prerequisite Readings: Module 3 (Scheduling)

Assignment:

1. Design and turn in a copy of a classroom schedule which includes:
   a. delineation of teaching assistant time.
   b. delineation of teacher time.
   c. delineation of student time.
   d. at least 1, but no more than 2 1:1 sessions for yourself.
   e. at least 2 sessions in which you teach 2 students (Small Group) at the same time, for yourself.
   f. remember to use behavior clusters (teaching sequences) of 2 or more behaviors for all students. Other staff do not have to use teaching sequences, but you must.
   g. at least 1 group of 3 students (if all are ambulatory) or 4 students (if some are nonambulatory) for yourself (Large group).
   h. be sure to schedule yourself with a student at lunch.
   i. you should cover different domains (leasure, preacademic, self-help, etc.) in each group.
   j. sessions can be from 15-45 minutes apiece.
   k. each teaching assistant should have responsibility for at least 2 programming sessions.
2. Check classroom schedule by making and turning in at least 1 student schedule. (You will be responsible for all students' individual schedules. This will be checked twice during the semester.)
3. Complete the questions on the following pages and revise schedules as needed.

Rationale: A schedule needs to be designed in order to be sure work is distributed fairly across staff members and to be sure each student is getting the training he/she needs.

Criteria: 1. 2 tries. The following will be considered when grading: Is each student receiving all prgrams, designation of who is teaching what to whom, designation of time at which each teaching event occurs, breaks for each staff member, designation of any activities (such as speech, OT, etc.) to which the student must go at designated times.

2. Acceptable/not acceptable; however, this will need to be revised until it is acceptable.

3. Acceptable/not acceptable; however, this will need to be revised until the questions are answered clearly and are feasible.

Special Instructions: Following the questions is an example of a schedule for small groups, which shows one method of dealing with the question of designating what will be taught when using ICS teaching sequences. Tape-on-Tape schedules are advised as there may be extensive revisions necessary.

Try not to mess up the current schedule for other people any more than necessary. The more you alter others' schedules, the more work there will be for you to do in the next exercises.

QUESTIONS FOR ASSIGNMENT 3

1. What happens when one or more students are late? ____________________

   ____

2. Do the student activities which occur at the same time require the same materials? __________ How do you plan to deal with this problem? __________

   ____

   ____

3. Do the student activities which occur at the same time require simultaneous use of the same training area (for example, sinks)? ____________________
   How can you solve this problem? ____________________

   ____

4. Are there any parts of the schedule which demand combinations of student behavior which are incompatible, e.g. music training at the same time as attention training? __________ How can you deal with this problem?

   ____

   ____

5. Mark in red pencil, the activities which will occur when one teacher or teacher's aide is absent (assuming there is no substitute).
   Do you think it would be wise to devise an alternate schedule for days when someone is absent? ____________________

6. How is a signal given to change activities? ____________________

   ____

   ____

7. If a trainer has not finished a task or teaching sequence with a student when the change activities signal is given, should s/he attempt to complete the task or send the student on to the next activity? __________

   ____

8. List which staff memeber is responsible for which students in an emergency situation (e.g. fire drill).

   ____

   ____

   ____

Teachers / Time	Georgeanne	Carolyn	Jean	Jackie
12:00	Kenny: eating, sitting up straight, hand in lap	Michelle: eating, raise spoon to mouth, waiting between bites	12:00-12:30 --free 12:30-1:00 lunch program	Assist Suzanne, Mik Sherry, Darrick, Laura, & Timmy with any problem they may have at lunch. 12:30-1:00 free
12:45	Kenny, Timmy & Mike: empty trash from classrooms and push chairs under table	Suzanne & Laura: wash & dry dishes Sherry: put dishes away	Darrick: sweep floor Michelle: wipe table	Kenny & Michelle: toileting, tooth brushing, handwashing
1:00	Darrick, Suzanne, Sherry: toothbrushing, toileting. Desk work: Suzanne--puzzle Darrick--lite brite Sherry--viewmaster	Laura, Mike & Timmy: Toothbrushing & toileting. Desk work for each: name and color	Kenny & Michelle: language: tactile communication & imitation of beginning sounds. Discrimination of beginning sounds.	Assist students with desk work
1:30	Darrick, Suzanne, Sherry, & Kenny: motor imitation; open milk, pour, open jar, spread peanut butter, exercises, conversation.	Break and check programs	Laura & Timmy: pre-math, matching number to number. Match and sort identical spoons and cups.	Mike: pre-math, object to object match. Language; imitation of begi ning sounds. Communication; receptive. Pictures from pre-math.
2:00	Mike: function of object--car, comb, ball Kenny: recognition of object--pipe, ball Michelle: receptive lang.--give me (ball, doll, cat)	Darrick: recognition of objects (car, truck, ball) Sherry: same--(comb, deoderant, soap) Laura: same--(nuts, screws, bolts)	Tim & Kenny: empty classroom trash and clean trash cans	Toilet students
2:20	Sherry, Timmy & Michelle: coat on, hat on, zipping	Laura, Kenny & Mike: coat on, hat on, zipping	Suzanne: coat on, hat on, zipping	Darrick: coat on, hat on, zipping

ASSIGNMENT 4

Prerequisite Readings: Module 24, Kansas State Plan

Assignment: Specify and define the responsibilities of the teaching assistants in your classroom. Determine where this role might overlap with the teacher's responsibilities.

Rationale: Each staff member should have clearly defined and accepted responsibilities. The efficiency and effectiveness of a classroom depends on the cooperative effort of the teaching team.

Criteria: The grading of this assignment will be determined by the clarity of role delineation and appropriateness of responsibilities chosen. No responsibilities should be required which conflict with the Kansas State Plan.

There is one try. This assignment is graded A, B, or C. However, revisions will be required until it meets all the criteria.

Special Instructions:

1) If you do not have your own classroom, anticipate what responsibilities you would have your assistants perform in a classroom of your choice.

2) If there are no assistants in your classroom, theorize what you would delineate roles to be in a classroom with one teacher, three paraprofessionals and eight students.

ASSIGNMENT 5

Prerequisite Readings: Module 24

Assignment:

1. Outline the strategies you could use to train teaching assistants some aspect of classroom management, student characteristics, or programming skills.
2. Begin implementing training procedures with at least one of your assistants.

Rationale: Many assistants come to the classroom inexperienced and need training to understand the students, classroom management principles and programming skills.

Criteria:

1. Your grade for this assignment will be dependent on how well the training is organized, whether the material is clearly presented, and whether all essential areas are covered. This is graded A or C.
2. This is graded Acceptable/Not Acceptable, however, it will have to be repeated until it is acceptable.

Supervisor: Will attend one training session.

Special Instructions:

1. If you are fulfilling practicum assignments in someone else's classroom, complete the outline as you would use it in the future and choose one section which would be applicable to present to the teaching assistants in this classroom.
2. If your teaching assistants are already trained in basic skill areas, choose an area to expand and present more detailed information on the subject.
3. If you have no teaching assistants, theorize how you would train them if you were in a classroom of eight severely multiply handicapped school aged students, with three teaching assistants.

ASSIGNMENT 6

Prerequisite Readings: Module 24

Assignment:	Develop strategies for the utilization of assistants in your classroom. Include scheduling, supervision, and accountability procedures.
Rationale:	In addition to defining roles and responsibilities, the teacher will need to learn to utilize and supervise the assistant in the classroom.
Criteria:	Include in your strategies: a) a schedule for the periodic evaluation/observation of each assistant, b) a set of checklists to use to monitor the performance of your teaching assistants, and c) an outline or description explaining the checklists.
Special Instructions:	If you are not in your own classroom, or if you do not have teaching assistants, pretend you do.

ASSIGNMENT 7

Prerequisite Readings: Module 24

Assignment:

1. Develop a listing of services available in your community that might be of assistance to families with handicapped children. Include the following: (See sample on page 11)
    a) Services available
    b) Agencies that offer the services
    c) Agencies' locations and hours
    d) Procedures for applying for services
    e) Criteria for receiving services
    f) Persons to contact
    g) Fees for services
2. Plan a method for disseminating the information. Chose from one of the following:
    a) Include in school newsletters
    b) Presentation at parent meeting
    c) Place information in classroom and easy access locations (i.e. bulletin board)
    d) Handbook
    e) Discuss at individual conferences

Rationale: Sometimes families come to school personnel with problems that the staff are not trained to handle. Or, the staff may notice the family needs services that the school does not offer. To help parents in these instances, it is essential that teachers know basic information about services in the local community. These services may also provide help for the teacher in consultation, reference, assessment, etc.

Criteria: This assignment should include at least 10 community services. If you community does not offer at least 10 services, look for others within a 60 mile radius, or places parents could write for resources.

Special Note: Parents of handicapped students are a valuable resource in collecting this information. Consider using this as one of your parent involvement component activities.

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SAMPLE RESOURCE FILE INFORMATION SHEET

INFANT PROGRAMS

Durham County Health Department
300 East Main Street
Durham, North Carolina 27702
Telephone: 682-8176

Though not limited to infant care or Mental Retardation programs in its broad scope of functions, this agency cooperates with private physicians and other agencies in prevention and early detection of Retardation. It also works toward continuance of treatment, care, and training of the retarded child. Services include genetic counseling, immunization, well-child clinics, blood tests, health education, visiting nurses, and physical therapists.

Director: O. Ader, M.D., M.P.H
Contact Person: Nursing Office
Eligibility: No restrictions, generally. Some clinics are restricted to persons of limited financial means.

SOCIAL SERVICES

Durham County Department of Social Services
202 East Main Street
Durham, North Carolina 27702

This agency has a multiplicity of services available to the retarded and their families, though the services are not exclusively designed for this select group. Some of the services which are specifically applicable to the retarded are listed below.

Financial

a. Aid to the permanently and totally disabled - ages 18 to 65 who are disabled and meet other legal requirements.
b. Boarding Home Care.

Non-Financial

a. Placement of individual in Family Care Homes.
b. Request court appointed personal representatives for clients unable to handle public assistance checks.
c. Protective services for children and adults.
d. Psychological evaluations.
e. Assistance with application procedures for Murdoch Center.

Director: Thomas Hogan
Contact Person: if case is active with a social worker, contact that worker. If there has been no previous contact with the agency, contact the Child Welfare Intake Worker or Adult Intake Worker.
Eligibility: Residents of Durham County
Fees: None

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ASSIGNMENT 8

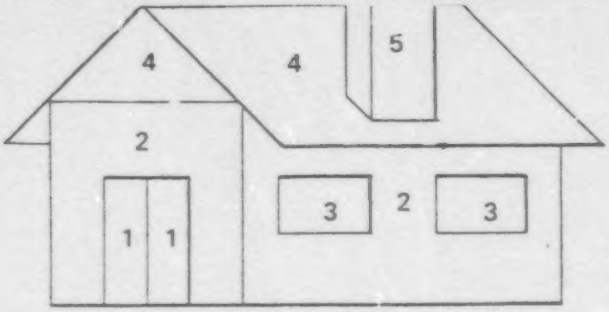
Prerequisite Readings: Module 24

Assignment: 1. Evaluate your program's overall orientation in regard to the role of the families. Two examples are provided on pages 13 and 14.

2. Determine through personal interview or written contact the needs of families in regard to your parent involvement program. An example needs assessment is provided on page 15.

Rationale: A needs assessment of both program and parents will help you determine priority items for each group and will clarify points to be developed.

Criteria: Completion of evaluations and evidence of analyzing and determining outcomes of the assessments.



Color Key
R-Red
B-Blue
Y-Yellow
G-Green
(See Key at bottom of this page for color interpretation)

COLOR YOUR SCHOOL
(An Activity for Assessing Program Orientation)

1. **The main focus of service for our center is in:**
   - B - Training the child to his maximum potential and expecting the family to help in your training of the child.
   - G - Working with the family to provide the most meaningful program for child
   - R - Having a smoothly operating child-care program.
   - Y - Training the child to his maximum potential

2. **In order to provide the best service, our center has:**
   - Y - Set policies that are in the best interest of the child.
   - B - Set policies that are in the best interest of the child but are also acceptable to parents.
   - R - Decided on center policies and followed them consistently.
   - G - Involved the families in setting center policies.

3. **Our center program and goals are set by:**
   - G - Committees or boards composed of staff members and parents.
   - Y - The director and/or lead teacher based on their knowledge and concern for the children's needs.
   - R - The director and/or lead teacher based on his or her professional knowledge of good program planning.
   - B - The director and/or lead teacher based on their knowledge and concern for the children's needs, but parents are asked to assist in reaching goals.

4. **The importance of individualization is shown in our program by:**
   - R - Helping the child adjust to our program.
   - B - Evaluating the child's developmental level through classroom assessment and interview with the family so as to determine what must be done for the family.
   - G - Evaluating the child's developmental level, family assets, training and service needs, and by shared goal-setting with family.
   - Y - Evaluating the child's developmental level as a basis for setting appropriate goals for him.

5. **We evaluate our program by:**
   - G - Successfulness in meeting objectives set by parents and center personnel.
   - R - The smoothness of its operation.
   - Y - The effect of program on the child.
   - B - The effect of program on the child and what we can do with the family.

Key: (see Chapter 9)
Red - The Institutional Approach
Blue - The Child Center Approach
Yellow - The Modified Child Centered Approach
Green - The Family Oriented Approach

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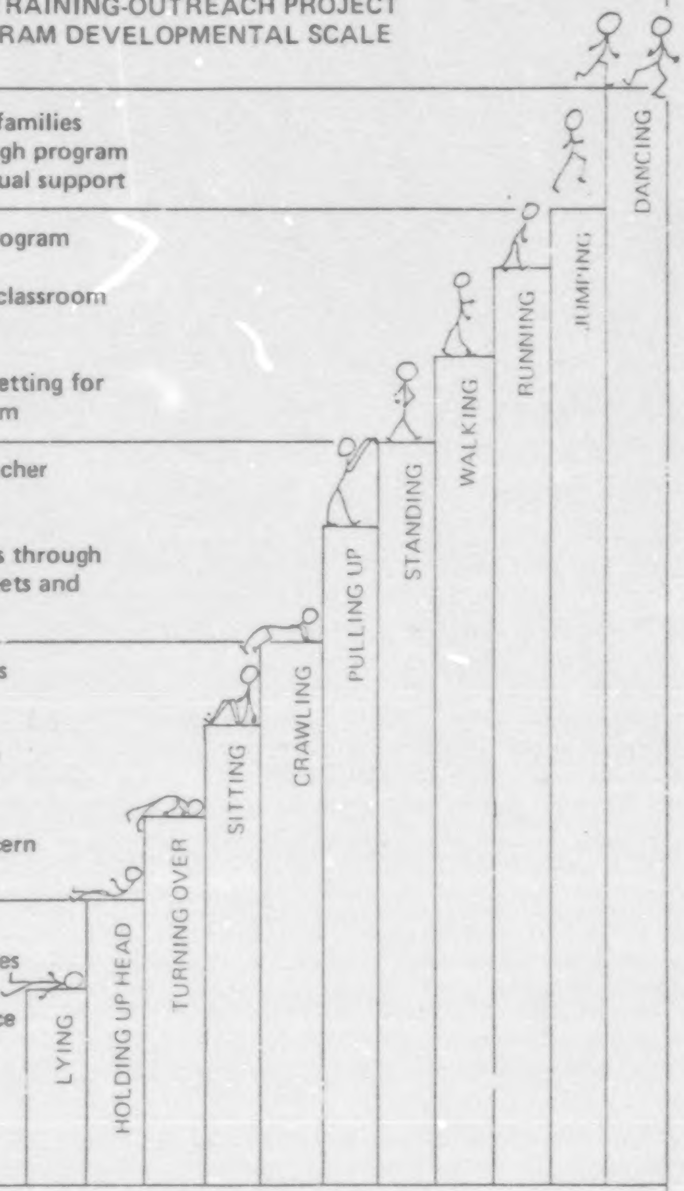
CHAPEL HILL TRAINING-OUTREACH PROJECT
FAMILY PROGRAM DEVELOPMENTAL SCALE

YOU'VE MADE IT	Recognizing and supporting families in achieving their goals through program planning, advocacy, and mutual support
MILDLY DELAYED	Developing Home Visiting Program Opening doors of center for classroom observation Parent participation in goal-setting for their child and family program
MODERATELY DELAYED	Regular individual parent teacher conferences Communicating with families through P.T.A., Home Follow-up Sheets and Newsletter
SEVERELY DELAYED	Beginning skills of techniques for involving families Seeking knowledge of family dynamics and family needs Acquiring empathy and concern for family needs
PROFOUNDLY DELAYED	Informing families of rules, regulations and responsibilities Ignoring families. Indifference to their needs



What is your family P.D.Q. (Program Developmental Quotient)?

Is your program Developmentally Delayed?

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SAMPLE NEEDS ASSESSMENT FORM
PARENTAL RATING OF NEEDS FOR SERVICE

It is our feeling that a child's progress in school is greatest when staff and family form a cooperative team with common goals. To have an effective family-staff team, parents should be given the opportunity to express what they feel are their expectations and limitations in relation to such a program. Will you please rate the following areas for service according to their importance to you.

Please Check:

	Not Important	**Some Importance**	**Very Important**
1. Training in classroom activities and teaching methods.			
2. Interpretation of test results.			
3. Counseling for family problems.			
4. Suggestions of other available services in the community.			
5. Help with managing behavior of children (temper tantrums, toilet training, eating habits, etc.)			
6. Transportation			
7. Suggestions for home activities for child.			
8. Training for brothers and sisters of child.			
9. Meetings for groups of parents.			
10. Suggestions for inexpensive or home made learning and play materials.			

What do you think would be the most helpful format for parent-staff contacts? Check one or more.

______ group meetings with information-sharing (lecture-discussion) on general areas of interest
______ small-group discussion on topics selected by participating parents
______ periodic individual conferences between parent(s) and staff member(s). How often? ____________________
______ visits to families' homes by staff member
______ classroom observation and participation by parents
______ all of the above, depending on need at the time
______ I do not feel that parents should be involved in child's education program
______ Other

Thank you for your comments.

Name ____________________

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ASSIGNMENT 9

Prerequisite Readings: Module 24

Assignment: Based on the needs assessment of 2 of the families from Assignment 8:

1. Plan strategies for the implementation of your family-based educational program. Remember that no one strategy will work with all your families. Therefore it is important to plan a variety of strategies.

2. Prepare and present your strategy plan to your immediate supervisor or administrator.

Rationale: This assignment will help the teacher begin implementing procedures to develop a family based educational program.

Criteria: Acceptance by your program staff and administration to develop a parent involvement program.

ASSIGNMENT 10

Prerequisite Readings: Module 24 and Module 6

Assignment: Schedule and implement one IEP Conference (this is preferred) or one parent conference. This conference should cover how the student is currently doing, ask for input from the parents, and outline future plans for the student's education.

Supervisor: Will observe conference or arrange for building/program supervisor to observe.

Criteria: One try. The following will be considered when grading:

a) Implementation of techniques to achieve parental participation.
b) Evidence of written notification of parents of conference and rescheduling if necessary.
c) Accuracy of information conveyed.
d) Clarity of information presented--based on how well parent seems to understand.
e) General tone of conference--positive remarks about student and acceptance of parental input.

Special Instructions: If concurrently taking SPED 779 (Parental Conferencing), your required parent conference for that course can be used for credit on this assignment. However, you must arrange for your supervisor to be present at the conference.

ASSIGNMENT 11

Prerequisite Readings: Module 3

Assignment:
1. Identify a 2 program skill cluster for 2 students who will be in a group together.
2. List the sequence in which the behaviors will be taught across the students (i.e. are you alternating students after behavior, every other behavior, or after 3 trials of the teaching sequence).
3. Identify the structure and content (see Brown, Holvoet, Guess and Mulligan, in Module 3) of the group.*

Rationale: Practice in devising training sequences which can be used in a group.

Criteria & Grading: The following will be considered when grading:

1) Functionality
2) Age-appropriateness of programs
3) Program cohesiveness
4) Correct identification of structure and content
5) Compatability of skill clusters (for both the single student and the group).

One try.

Special Instructions:

*1. This program may be intrasequential or intersequential. Assignment 14 however must be intersequential.

2. Remember to update your files!

ASSIGNMENT 12

Prerequisite Readings: Modules 3, 6, 7, 10-21

Assignment:
1. Write instructional programs for each skill to be taught in the group
2. Design a data sheet(s) that is appropriate to use in the group.
3. Design the necessary graphs for each student in the group.

Rationale: Maintenance of writing programs and designing data sheets and graphs.

Criteria: One try. The following will be considered when grading:

a. program format
b. data sheet format
c. graph format

Special Instructions: Send a copy of your programs, data sheets and graphs to your supervisor for feedback. You may begin baseline on the skill clusters before receiving feedback, but do not begin training until you have obtained approval. If you have time it might be advisable to await approval before beginning baseline.

ASSIGNMENT 13

Prerequisite Readings: Modules 3, 10 and 11

Assignment: Implement your group programs (don't forget to do a baseline on all behaviors which need one) and record data.

Rationale: It is imperative to be able to smoothly manage group programs as well as 1:1 training to be a successful SMH teacher. Current research shows that group teaching can be as effective as 1:1 and is more economical of a teacher's time.

Criteria: Two tries. See Group Activity Evaluation for specific variables your supervisor will be attending to.

Supervisor: Will observe the group program.

Special Instructions: One of the most important techniques for group control appears to be teacher mobility and alertness. This usually means that a teacher with an ambulatory group cannot sit and still maintain control. You need to be able to get to any member of the group quickly. Environmental design can also help control the student's tendencies to leave the group. Be sure the students are placed far enough from each other that they don't interfere with each other's programs, but close enough to watch one another.

ASSIGNMENT 14

Prerequisite Readings: Module 3

Assignment: Group Program

1. Identify a 3 program skill cluster for at least 3 students. Be sure that each student is involved in at least one intersequential interaction.

2. List the sequence in which the behaviors will be taught across the students (i.e. are you alternating students after each behavior, every other behavior, or after three trials of the teaching sequence).

3. Identify the structure and content of the group (see Brown, Holvoet, Guess and Mulligan, Module 3).

Rationale: Practice in devising training sequences which can be used in a group; specifically development of an intersequential group.

Criteria & Grading: One try. The following will be considered when grading:

1) functionality
2) age-appropriateness of programs
3) program cohesiveness
4) correct identification of structure and content
5) compatibility of skill clusters (for both the student and the group.

Special Instructions: Be sure to update your files!

ASSIGNMENT 15

Prerequisite Readings: Modules 3, 6, 7, 10-21

Assignment:

1. Write instructional programs for each skill to be taught in the group. (Remember that the Intersequential interaction should be a skill that the student needs to learn and therefore will probably need to be written up into an instructional program).

2. Design a data sheet that is appropriate to use in the group.

3. Design the necessary graphs for each student in the group.

Rationale: Maintenance of writing programs and designing data sheets and graphs; specifically, writing a program for an interaction.

Criteria: One try. The following will be considered when grading:

a. program format
b. data sheet format
c. graph format

Special Instructions: Send a copy of your programs, data sheets and graphs to your supervisor for feedback. You may begin baseline on the skill clusters before receiving feedback, but do not begin training until you have obtained approval. If you have time it might be advisable to await approval before beginning baseline.

ASSIGNMENT 16

Prerequisite Readings: Modules 3, 10, and 11

Assignment: Implement the group program (don't forget to do a baseline on all behaviors which need one) and record data.

Rationale: It is imperative to be able to smoothly manage group programs as well as 1:1 training to be a successful SMH teacher. Current research shows that group teaching can be as effective as 1:1 and is more economical of a teacher's time.

Criteria: Two tries. See Group Activity Evaluation for specific variables your supervisor will be attending to.

Supervisor: Will observe the group program.

Special Instructions: One of the most important techniques for group control appears to be teacher mobility and alertness. This usually means that a teacher with an ambulatory group cannot sit and still maintain control. You need to be able to get to any member of the group quickly. Environmental design can also help control the student's tendencies to leave the group. Be sure the students are placed far enough from each other that they don't interfere with each other's programs, but close enough to watch one another.

ASSIGNMENT 17

Prerequisite Readings: Module 8

Assignment:

1. Do at least monthly (preferably every 2 weeks) program reviews on both groups, changing programs as needed. Include a copy of the program graphs.
2. Update program monitoring cards in STEP file.
3. Communicate any changes to other classroom personnel.

Rationale: Practice in looking at data and making data-based decisions about group programs. A change in one student's program may affect all members in the group, so data decisions become more difficult in this situation. Also practice in maintaining classroom records and staff communication.

Criteria: One try per review. Two sets of program reviews are required for each program. The following will be considered when grading:

a. Correct evaluation of data trends.
b. Appropriateness of changes (or no change) suggested.
c. Identification of training problems in individuals or group.
d. Evidence of consistent program review.
e. Evidence that staff members are aware of and carrying out recommended changes or are maintaining program (whichever applicable).

Special Instructions: Be sure you begin your group programs early enough so that you have time to collect enough data for the program reviews. These reviews should have approximately 7-10 data points before any decision can be made.

ASSIGNMENT 18

Prerequisite Readings: All Modules

Assignment: General Classroom Management. (Note: This assignment should have been ongoing all semester.)

Rationale: It is important that the teacher be able to manage all aspects of the total classroom simultaneously.

Criteria: This assignment will be evaluated (using the General Classroom Observation form) 2 times during the semester; once at midsemester and once at the end of the semester. There will only be one try for each of the observations.

Evaluation will be on all ongoing programs in the classroom, i.e. all students.

ASSIGNMENT 19

Prerequisite Readings: Module 12

Assignment: From the designated student's programs outlined in Assignment 2, list one or two discrimination programs which might be taught using errorless stimulus control procedures.

Rationale: Identification of objectives that might be appropriate for this specific type of training technique.

Criteria: One try. The following will be considered when grading:

a) functionality of program
b) age-appropriateness of program (if relevant)
c) least restrictive alternative
d) appropriateness for errorless training

This assignment will be graded Acceptable/Not Acceptable.

ASSIGNMENT 20

Prerequisite Readings: Module 12 (You should carefully reread this module as you do these assignments). Utilize your supervisor and other resource personnel as much as possible.

Assignment:

1. Decide on a technique which you would use to teach the discrimination.
2. Describe pretest/posttest criterion level stimuli materials that could be used.
3. List prerequisite entry level skills for pretest (pointing, matching, picking blank card, etc.).
4. Describe tests in a format similar to the pretest, but not using actual pretest materials to test these prerequisite skills.
5. Devise data sheet for pretest/posttest.

Rationale: Practice in the preliminary steps of errorless design.

Criteria: Two tries. The following will be considered when grading:

a) choice of appropriate training technique
b) design of program is such that student probably already has entry skills or can easily learn them
c) pretest and posttest contain same items, are same format, and are criterion level discrimination
d) identification of obvious prerequisites
e) data sheet that is made for recording type of error
f) good data sheet format
g) a summary and comments section on data sheet
h) some method of designating how items should be presented to the student to keep from developing position habit
i) designation of correct response (if necessary).

Special Instructions: Sometimes the easiest way to make a data sheet for errorless programming is to draw a layout of the stimuli for each trial and then mark what the student chooses.

ASSIGNMENT 21

Prerequisite Readings: Module 12 and input from supervisor or other resource personnel.

Assignment: Sketch errorless training materials that would be appropriate for training. These materials should exemplify the errorless procedure.

Criteria: This assignment will be graded Acceptable/Not Acceptable. Your supervisor will be looking at:

a. strategy of training materials, e.g. use of fading, superimposing, and,
b. relevancy of materials to target behavior.

Special Instructions: Do not spend too much time in the design of the materials; simply sketching out several pictures that show the stimulus changes should suffice.

General Classroom Observation

(For all students in the class)

Written Programs: Total number of programs ______ Number missing _____

A. Some format for all ongoing programs

	# missing
1. Title	
2. Rationale	
3. Behavioral objective	
4. Definition of response	
5. Materials	
6. Cue	
7. Correction Procedure	
8. Data recording	

Graphing: Total number of graphs _______ Number missing _____

A. Uses correct format

	# missing
1. Ordinate labeled	
2. Abscissa dated	
3. Criterion line	
4. Ceiling line	
5. Phase change lines	

B. Data Decisions

1. Baseline changed to training at appropriate point.	
2. Procedures changed on or before 10 days of non-criterion performance.	
3. Activity changed after specified number of criterion days.	

Scheduling

A. Posted Classroom Schedule (showing teacher's assistants and students activities). Yes No

B. Related to ongoing activity (observe 3 times) ☐ ☐ ☐

C. Individual schedule for each student in class (specify program title)

1. Coincides with class schedule How many? Yes ☐ No ☐
2. No student with more than 1 hour of down time in 6 hour day. How many? Yes ☐ No ☐
3. Each student in at least 2 (small) groups. How many? Yes ☐ No ☐

Group Observation Form

(Adapted from the Early On Program)

Students/ # of behaviors per sequence
________ / ____
________ / ____
________ / ____
________ / ____
________ / ____

Theme: ____________
Teacher: ____________
Observer: ____________
Date: ____________
Time: ____________

Prior to Conducting Session Trainer:

1. Has all required materials yes no
2. Has all programs in classroom yes no
3. Data sheet
    a. indicates each Student's name yes no
    b. indicates each student's step yes no
    c. indicates each student's correction code yes no

During Training (each trial reflects entire sequence)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
5. Materials a. discriminable															
b. positioned optimally															
c. out of other students reach															

6. Cues a. clear															
b. correct wording															
c. not repeated															
d. S's positioned optimally															

7. Reinforcement: Individual a. at correct time in sequence															
b. immediate															
c. paired															
d. schedule correct															
e. appropriate intensity															
8. Follows sequence															
9. Corrects each behavior w/in sequence															

10. Handles inappropriates a. interrupts priority beh. probl.															
b. returns to sequence															
c. completes beh. prog. when applic.															
d. prevents occassion for following behavior problems															

Group Observation Form
Page 2

Score After Training:

11.	Sequencing			
a.	correction procedure appropriate length	yes	no	
b.	sequence appropriate length	yes	no	
c.	trials alternated between student	yes	no	
d.	trials alternatied within student	yes	no	
e.	pacing appropriate	yes	no	
f.	takes data at realistic intervals	yes	no	
12.	Seating arrangement			
a.	next to complimentary student	yes	no	
b.	close enough to students to have contact	yes	no	
13.	Content			
a.	common theme	yes	no	na
b.	intermittent "programmed" interaction between S's or behaviors (S's as antecedents)	yes	no	na
c.	behavior checks	yes	no	na
14.	Use of aides (if applicable)			
a.	aides have structured responsibility	yes	no	

STEP File Check

I. Cover Information

- A. Student's full name
- B. Birthdate
- C. Parents name
- D. Parent's address
- E. Parent's telephone number
- F. Student's residence
- G. Emergency contact and phone number
- H. Doctor's name and phone number
- I. Preferred hospital
- J. Current education placement

II. Precautionary Information

- A. Health
  - 1. Allergies
  - 2. Immunizations (what/date)
  - 3. Handicaps
- B. Medications
  - 1. Medication name
  - 2. Amount
  - 3. Start date
  - 4. Stop date
- C. Danger
  - 1. Behavior problems
  - 2. Orthopedic precautions

III. Orthopedic

- A. Positioning
  - 1. Beneficial positions
  - 2. Transfers
  - 3. Carries
- B. Adaptive Equipment/Materials
  - 1. Date equipment use began
  - 2. Equipment/material, ie. arm sling, built-up spoon, etc.
  - 3. Program/time, ie. mealtime, hairbrushing, etc.

IV. Standardized Test Data

- A. Date test given
- B. Name of test and score

V. Educational Objectives
- A. Objective
- B. Curricular domain of objective, ie. fine motor, self-help, etc.
- C. Priority level of objective, ie. high priority, future objective, etc.
- D. Current status of objective, ie. ongoing, not implemented, on hold, etc.

STEP file (cont.)

VI. Program Implementation

- A. Ongoing programs
    - 1. Title of program
    - 2. Behavioral objective
    - 3. Overview of program
        - a. Definition of response
        - b. Correction procedure
        - c. Data taking, ie. +, -; 2,1,0; etc.
        - d. Criterion
- B. Program monitoring
    - 1. Program and data reviews
    - 2. Subsequent decision making
    - 3. Reliability data and dates
    - 4. Audio-visual records

PROGRAM REVIEW FORM

Student: ______________________________

Program: ______________________________

Step #: ______________________________

Trainer(s): ______________________________

Reinforcer: ______________________________

Date: ____________________

Program Summary

Program Plan:

Program is:

Possible Program Changes:(List at least 3)

1.

2.

3.

Program Decision

Chosen Program Change: # ________

Date Implemented: ____________

☐ Recorded in STEP

Statewide Inservice Training Project for Teachers of the Severely-Multiply Handicapped, Department of Special Education, The University of Kansas.

MEDICAL ASPECTS IN THE CLASSROOM
(Module 14b)

Lesley Fernandez, Gayle Yelenik, Gwen Benson, Fredda Brown & Doug Guess
Statewide Inservice Training Project
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The University of Kansas Department of Special Education

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Statewide Inservice Training Project
for Teachers of the Severely Multiply Handicapped
The University of Kansas, Department of Special Education
Competency Specifications for:

MEDICAL ASPECTS IN THE CLASSROOM

INFORMATIONAL COMPETENCIES

A teacher of the severely and multiply handicapped should acquire the information necessary in understanding how medical aspects relate to the classroom. This includes general and emergency classroom procedures, the transdisciplinary approach, special topics relating to students with sensory impairments and abused children, and specific syndromes and their medical implications. The teacher should acquire this information through the readings of the module and demonstrate the acquisition of this information by correctly answering test questions about:

1. Important factors contributing to personal hygiene in the SMH classroom.
2. Important factors contributing to maintenance of general classroom hygiene.
3. The purpose of a health check and possible methods for conducting a health check.
4. The guidelines for administering medications.
5. The importance of establishing a policy for non-health personnel to administer medications.
6. Three areas which will facilitate advance preparation of the staff in handling an emergency situation.
7. Four types of seizures frequently experienced by children.
8. Possible health problems and emergency situations which might be encountered by a classroom staff.
9. Two major areas in which the deaf-blind student is at a disadvantage.
10. Tactual augmentations for the three communication modes: oral, manual, and symbolic.
11. Guidelines for teaching a deaf-blind student.
12. Certification definition of deaf-blind.
13. Two situations in which teachers and other professionals have contact.
14. Seven referral categories.
15. General referral guidelines.

INFORMATIONAL COMPETENCIES (Cont.)

16. Three areas outlined by Iacino and Bricker in which teachers must work with consultants.

17. Teachers' legal responsibilities concerning suspected child abuse.

18. Characteristics and medical implications of specified syndromes.

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OVERVIEW

First read the Yelenik section covering general classroom and emergency procedures. This will provide you with information on health-related aspects as they relate to the severely/multiply handicapped classroom.

Next read the article by Fernandez in which professional relationships between teachers and other professionals are discussed.

The second article by Fernandez is "Two Special Topics: The Deaf-Blind Student and The Abused Child." Special needs, considerations and responsibilities as they relate to these two topics are discussed.

Finally, the section by Benson will serve as a resource for referring to different syndromes. Areas covered include etiology and characteristics, nutritional implications, medical side effects and general health implications. A glossary of medical terms is also provided.

General and Emergency Classroom Procedures: Health Aspects

Gayle Yelenik

In a classroom for teaching the severely and multiply handicapped, there will be students who exhibit a wide range of handicaps that require special attention. For this reason, information regarding the medical aspects of supervising a classroom is essential. This paper is intended to provide the classroom staff with ideas of what factors must be considered in order to make the classroom environment as safe and as medically conscious as possible. General classroom procedures as well as emergency procedures will be discussed.

General Classroom Procedures

Sanitation

An important factor which contributes to minimizing the spread of disease in the classroom is in the area of sanitation. Maintaining cleanliness in the classroom environment is critical. There are many areas which must be considered in providing for a sanitary environment in a severely and multiply handicapped classroom. The teacher should include these areas as part of the general classroom organizational procedures to ensure that all classroom staff members are aware of these additional responsibilities.

Personal Hygiene. It is important that good personal hygiene be emphasized. In the teaching of self-help skills such as eating, drinking, facewashing, hairbrushing, and toothbrushing, individual materials for each student should be used. Thoroughly clean any dishes, utensils, glasses, or bibs used in feeding programs in the classroom each time they are used.

In the toileting area, it is especially critical to maintain cleanliness. The following procedures outlined by Jones and Taylor (Note 1) will aid in this effort.

1. Immediately rinse and dispose of diapers.
2. Place wet clothes in individual plastic bags to be returned home for laundering.
3. Place used washcloths, towels, etc. in an appropriate container.
4. Wash hands thoroughly before handling other children, materials or equipment.
5. Daily cleaning and disinfecting of commodes, diaper table and diaper pail.

General Classroom Hygiene. There are other responsibilities to be included as part of general classroom procedures in order to maintain cleanliness in the SMH classroom. It may be necessary for the teacher to designate individual staff persons to assume responsibility for seeing that these tasks are completed. This could be done either by formally assigning tasks as part of a daily or weekly schedule or by informally assigning tasks according to need. It should also be kept in mind that in some SMH classrooms, students might be working with the staff members in learning how to carry out many of the "household" tasks. The acquisition of these tasks would contribute to the students' independent living skills. Following are some of the common tasks that every classroom must consider.

1. There is frequently a high occurrence of mouthing of toys and program materials by severely/multiply handicapped students. Therefore, it is necessary that these objects be washed regularly in order to minimize the spreading of germs in the classroom.
2. If blankets or mats are used in the classroom, they should be laundered or disinfected on a regular basis.
3. Tables, desktops, and chairs should be cleaned. It may also be necessary to clean the sink and its counter area daily.
4. Classrooms which are carpeted or have area rugs in them should be vacuumed on a regular basis.

5. Adaptive equipment should be checked and cleaned on a regularly scheduled basis. Protective maintenance of adapted and prosthetic equipment can prolong the use of the equipment, with less repair work being needed as well. Refer to Module 14, "Programming Adaptive Environment," pages 14-17 for maintenance guidelines on equipment (Fernandez and Murphy, Note 2).

6. If edibles are being used as reinforcers or for feeding programs being run in the classroom, it is critical that these food items be securely wrapped or enclosed and carefully stored. Negligence or haste in putting food away may attract unwanted insects or rodents and will also result in the wasting of food. It is essential to keep any kitchen-type areas in the classroom very clean.

It may be desirable for the classroom teacher to set up an informal communication system with the janitorial staff in order to work with them in maintaining a sanitary classroom environment.

Health Checks

The conducting of daily health checks is another area in which general classroom procedures can be developed in order to help minimize the spread of disease in the SMH classroom. Health checks are conducted by staff members as each student arrives to school. The check consists of examining each student for possible signs of illness or other health problems. This is important to help control contagion of illnesses among the rest of the students and staff members in the classroom, as well as help the individual student who is sick to get the necessary treatment.

The following procedures were developed by Jones and Taylor (Note 1) to conduct a health check:

1. Obtain materials: flashlight, pencil, parent report. As the parent completes the top portion of the daily report form (Figure 1) use the flashlight as necessary to quickly check the following:
    a. Scalp - cuts/scratches, rash, flaking dry skin, hair loss, lumps.
    b. Face - cuts/ scratches/sores, bruises/swelling, rash, pale/flush, feverish (feel forehead, neck, cheeks).
    c. Eyes - watery/glassy, inflamed, discharge/crusty.
    d. Nose - discharge, skin irritations.

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DAILY PARENT REPORT FORM

To be completed by parent

Child's name: ______________________ Date: ______________

Did your child sleep well last night?	YES	NO
Did your child eat breakfast?	YES	NO
Is your child feeling well today?	YES	NO

Phone number if different for today: ______________________

Special Instructions for today:

- -

To be completed by staff

Health check ______________ Comments:

Meals

Type of food/liquid - - Servings eaten

1

2

3

4

Nap

Child slept from ______________ to ______________.

Medication:

Type: Time:

Comments:

Staff Signature: ______________________

Figure 1; Daily Parent Report Form

e. Mouth, throat, gums - cracked lips (especially corners), intensely red lips, excessive mucus, sores in mouth or throat, red or white patches/spots in mouth or throat, red or swollen gums.
f. Neck - enlarged glands.
g. Trunk and Back - profuse sweating/feverish, rash (on cheek or lower abdomen).
h. Arms and legs - cuts and scratches, sores and bruises, rash.

(Remember: The child is being checked against what is normal for only that child, i.e., some children will be predisposed to larger tonsils, flaky skin, hair loss, etc. Become accustomed to these tendencies for all children and do not overreact to them.)

2. Following the check, if the child appears to be in good condition to enter the classroom, place a check mark in the slot beside the health check entry on the parent report form. Note any unusual sign under the comments section.

3. If the child's health status seems to indicate a need for concern the parent should be advised and appropriate action taken. The nurse should be consulted if there is any uncertainty about a child's health.

4. If the child needs to be sent home, be supportive and sympathetic with the parent for the unnecessary trip to the center.

Jones and Taylor also provide useful guidelines regarding normal and possible abnormal findings for hair, scalp, eyes, nose, lips, mouth, throat, neck, skin, and body temperature (see Table 1).

Because of the individual needs of a particular classroom the teacher may choose to develop his or her own method for conducting a daily health check. It is important then that as much input as possible be gotten from the school nurse. The classroom staff should also receive training in learning how to efficiently conduct a health check. The school nurse might want to demonstrate and then observe the first few health checks in order to provide feedback to the classroom staff. Parents should also be informed of the content of the health check and the method in which it is conducted.

It is also important to note throughout the school day any unusual behavior exhibited by a student which might indicate that he or she is not

Table 1

HEALTH CHECK GUIDELINES

	Normal Findings	Suspect Findings
Hair	Smooth, resilient texture	Dry, coarse, brittle texture, bald spots, white flakes.
Scalp	Smooth, pale or pink	Crusty, flakey, bright pink or red patches.
Eyes and Eyelids	White sclera, pink conjunctivae	Yellow or pink sclera, drooping eyelids, red conjunctivae, discharge, crusting.
Nose	Pink mucous membrane	White or yellow discharge.
Lips	Pink and moist	Dry, red, swelling, cracking, especially at corners.
Mouth and Throat	Pink, smooth mucus membranes	White patches, red and inflamed membranes.
Neck	Musculature and bony structures palpable	Nodules or "bumps" behind or in front of ears, under chin, sides of neck.
Skin		
Color	Individual variations	Pallor, flushing, yellow tinge or bluish.
Texture	Springy	Dry, flaking, does not spring back.
Temperature	Individual variations	Warm over face, abdomen, back
Lesions	None	Rashes over face, abdomen, back particularly suspect.
Body Temperature	96° - 101° F 35.6° - 38.2° C	Greater than 38.5° C or 101.3° F

feeling well. This might include crying, trembling, tantrumming, rubbing of eyes, excessive scratching or rubbing in a specific body area, or extreme lethargy. The staff should also be aware of possible problems caused by improperly fitting clothing or shoes which may be irritating the student.

If an illness or an injury is detected during the health check or later on in the school day, the appropriate measures must be taken according to the policies of the facility. All classroom staff members should be familiar with any necessary forms to be filled out and also know who is to be notified concerning the student's health conditions. If one student contacts a contagious illness that might easily spread to the other students in the classroom, the parents should be notified. They can then be made aware of any precautionary actions to be taken and possible symptoms to be watching for.

Administering of Medications

There may be students in a classroom for severely and multiply handicapped children who have health problems which require special medical attention. The effectiveness of medication in the treatment of chronic disabilities and illnesses may be allowing these students to participate in a full school day. Therefore, part of the general classroom procedures may have to include the administering of medication.

This is an area which must be dealt with cautiously. Each facility's policy may differ according to the regulations for administering student medications. Some school settings may only allow the school nurse to give the medicine. However, when a full-time nurse is not always available, other arrangements must be made. For example, an all day field trip involving a student who requires medication three times during the day would necessitate special arrangements.

If the teacher in a school district is given permission to administer medications to a student, then protective guidelines should be established for both the teacher and the student. The following guidelines are recommended by the Committee on School Health (1978):

1. Written orders from a physician should detail the names of the drug, dosage, time interval that the medication is to be taken, and diagnosis or reason for the medication to be given.
2. Written permission should be provided by the parent or guardian requesting that the school district comply with the physician's order.
3. Medication should be brought to school in a container appropriately labeled by the pharmacy or physician.
4. One member of the staff should be designated to handle this task, ideally the health personnel if available.
5. A locked cabinet should be provided for the storage of medication.
6. Opportunities should be provided for communication between the parent, school personnel, and physician regarding the efficacy of the medication administered during school hours.

If the teacher is designated to be responsible for administering the medication, then that responsibility should not be casually passed among the other staff members. Only appropriately trained staff should be allowed to administer medicine even though it may at times appear to be a relatively easy procedure. Even nonprescription medication, such as aspirin, ointments, and cold remedies should not be given without prior written permission of the child's parent or guardian. All information concerning medications, written permissions, etc. should be easily accessible in the classroom.

It is critical that a school policy be established and implemented regarding procedures for administering medication to students during the school day. This is for the legal protection of the teacher as well as for the medical protection of the student. It may be possible that liability coverage for the staff will be provided by the school district. It is up to each individual teacher to investigate and learn about the policy of his or her facility.

Emergency Classroom Procedures

It can never be predicted when certain types of emergencies, whether major or minor, might occur in a classroom for severely and multiply handicapped students. However, advance training and preparation for possible emergencies will enable the staff to better handle the situation.

First, it is important to identify any chronic illness or health problems which a student might have which could result in an emergency situation. All of the staff members who work with those students affected by health problems should then be made aware of typical symptoms to expect in the classroom. This will also enable them to make better judgements when problems do occur. These might include heart disorders, seizures, allergies (food, environmental, etc.), respiratory difficulties, bowel and bladder habits, the child's sleeping patterns, high susceptibility to earaches and colds, and any visual or hearing disorders.

The necessary medical information can be obtained by having the parents or guardian fill out a health form prior to the student's admission to the program. An example of this type of form appears in Figure 2 (Note 1). These forms should then be kept on file in the classroom. Another means of making this medical information quickly accessible to the staff would be to include it as part of the Student's Education Plan, or STEP file (Alderson and Brown, Note 3). This system of organizing various needed data about each student includes a section of precautionary information covering health and medications.

Secondly, it is very important that the classroom staff be trained in handling emergencies which may arise. Many schools are encouraging and

SEVERELY/MULTIPLY HANDICAPPED PRESCHOOL

HEALTH INFORMATION

Name ______________________ Date of Admission ____________

Date of Birth ______ ______________

Private Physician or Clinic ______________________

Address ______________________ Phone ____________

Specialty Clinics and Physicians

Neurology ______________

Orthopedic ______________

Cardiology ______________

Ophthalmology ______________

Other ______________

MEDICAL HISTORY

Medical Diagnosis ______________________

Prenatal History ______________________

____

Neonatal History ______________________

____

Major Illnesses ______________________

____

Hospitalizations ______________________

____

CHRONIC ILLNESSES AND HEALTH PROBLEMS

Seizures (Types) ______________ Frequency ____________

Signs of Seizures ______________________

Orthopedic Abnormalities ______________________

Heart Disease ______________________

Respiratory Disease (Asthma, Frequent Colds) ______________

Sensory Deficits (Vision, Hearing) ______________

Nutritional Problems (Special diets, etc.) ______________

Allergies (Food, Drug) ____________________

Bladder Habits ____________________

Bowel Habits ____________________

Sleep Habits ____________________

Other ____________________

CURRENT MEDICATIONS

Name	Dosage	Needed During School Hours?	Time

Special Equipment (Braces, etc.) ____________________

____

Figure 2: Health Information Form

providing for the participation of their staff in specialized emergency care training, such as cardiopulmonary resuscitation, commonly known as CPR. Other possible areas in which staff members should receive training include what to do as part of immediate first aid treatment, i.e. choking, seizures, cuts, abrasions, shock and acute trauma, respiratory difficulties, nosebleeds, ingestion of poisonous substances, head injuries, burns, fractures, fainting, and other health-threatening situations.

It is not possible to specifically cover all of the above mentioned areas in respect to providing emergency care. Therefore, only some of the more commonly occurring health problems found in an SMH classroom will be described and discussed.

Seizures

Seizures differ in terms of their frequency, duration, and pattern as well as the age at which they usually begin. It is important for the teacher and staff to have basic information about a child's seizures in order to gain an understanding of the medical treatment process.

Seizures are caused by abnormal electrical discharges of electrical energy in the brain. A seizure may manifest itself as convulsions, lapses of consciousness, involuntary simple motor movements, automatic performance of complex movements, or unusual memories or sensations. It is stated that:

> "to an observer, a seizure may be a sudden attack, usually manifested by a complete or partial loss of consciousness and accompanied by involuntary muscle movement or a cessation of body movement." (Gadow, 1979, p. 33)

The four types of seizures that are frequently found in an SMH classroom will be described.

Major Motor. The most common type of seizure is major motor, or grand mal (Gadow, 1979). These are the most serious in the classroom and require immediate attention. The child becomes tense, with the body stiffening, and then will slump to the floor unconscious. Breathing stops and the face may turn pale. This is followed by jerking movements of the body and limbs. The seizure may last for several minutes, and the child will regain consciousness in a confused or drowsy state.

The following steps should be taken when a student is having a major motor seizure:

1. Do not attempt to restrain or revive the child. You cannot stop a seizure once it has started.
2. Clear the area of hard, sharp, or hot objects which might cause injury. Gently position the child on the floor, preferably in a sidelying position, placing a pillow or rolled up coat under the head. If available, a coat or a blanket should be put over the child.
3. Turn the child's head to the side, making sure that the breathing is not obstructed. Loosen any tight clothing but do not interfere with any movements.
4. Carefully observe the child's actions and the time duration of the seizure. It may be necessary that a description of the seizure be formally reported to medical personnel.
5. If the student is having repetitious seizures without gaining consciousness in the interval, a medical emergency exists. The child should be immediately transported to a hospital for treatment of this rare complication of epilepsy called "status epilepticus" (Haslam and Valletutti, 1975).

After awakening from a seizure, many children will exhibit any of a variety of different reactions to the seizure, including fatigue and sore muscles. nausea or headache, and behavioral changes such as irritability, restlessness or even aggression (Gadow, 1979).

Petit Mal. Petit mal seizures are typically manifested as a sudden, brief loss of consciousness. They may be accompanied by staring or twitching of the eyelids and are frequently mistaken for "daydreaming"; there may also be slight clonic movements involving the eyebrows, head and arm. The actual seizure may last from 5 - 30 seconds, with up to 50 or 100 spells occurring per day. They may occur so frequently that they interfere with a child's concentration and consequently, the child's performance in school may decline. There are no first aid measures to be taken for petit mal seizures. It would be important to keep track, however, of the number of seizures that the student has and to maintain contact with the parents and physician.

Psychomotor. The third type of seizure is called psychomotor or temporal lobe. This type of seizure may be extremely difficult to identify, as it has the most complex pattern of behavior. These behaviors include constant chewing or lip smacking, purposeless walking or repetitious hand and arm movements, confusion, and dizziness. The psychomotor seizure may last from a minute to several hours.

Myoclonic. Myoclonic seizures are characterized by a twitching or jerking of skeletal muscles, usually of the head, neck, and arm. An individual muscle may contract or an entire limb may be involved. There is no apparent loss of consciousness during the attack. In handling either psychomotor or myoclonic seizures, it is important that the student be watched during an episode and that measures be taken to prevent any injury from occurring. Table 2 provides a chart for classifications of these types of epilepsy observed in children (Gadow, 1979).

Two of the most commonly used medications for controlling seizures are dilantin and mysoline, which are anticonvulsants. They are used to control generalized convulsive seizures and all forms of partial seizures. The medical side effects of dilantin may include anorexia, nausea, epigastric pain, hyperplasia (an increase in the number of cells which make up a tissue or organ), or hypersutism (unusual amounts of hair). More severe side effects may be ataxia, skin rash, or imflammation of the lymph glands. If mysoline is being taken, side effects may include anorexia, drowsiness, ataxia, or skin rash.

Following any type of seizure incident, the school should be informed of the convulsive disorder even if medication usually keeps the seizures under control (Gadow, 1979). Consult with the parents as well to determine what they do when their child has a seizure. It is also important to establish what the facility's policy is in regards to the procedure for reporting a seizure.

Allergies

The term allergy refers to an excessive and sometimes abnormal response of the body to foreign substances. These may be external reactions to a substance in the environment or an internal reaction to a particular food. Food allergies can cause eczema, intrinsic asthma, diarrhea, constipation, pains in the stomach, swelling of a part of the face or tongue, and migraines. It is also possible that a child may have an allergic reaction to a given medicine (Wels, 1978). Allergies to drugs may cause a rash, swelling in the face area, an extreme sensitivity to light, or other reactions such as asthma. If this is suspected by the teacher, it should be immediately reported to the physician. It is important for the classroom staff to be aware of any allergies which a student might have so that the student's environment can be modified accordingly. These allergies should be recorded in the student's individual records.

Asthma

Asthma can be a chronic or acute illness. It is a variable, reversible obstruction of the airways, and symptoms may include wheezing, shortness of breath, an irritating, tight cough and persistent sputum (Smith, 1978).

Table 2

Clinical and EEG features of classificational types of epilepsy observed in children*

Type of Epilepsy	Age at Onset	Seizure Pattern	Duration of Seizure	Frequency of Seizures	EEG Findings
Major Motor (grand mal)	May occur at any age	Generalized tonic-clonic tonic clonic atonic Focal	Variable: most commonly several to 5 minutes or so; however may last as long as one hour or longer	Variable	Nonspecific** abnormalities; interseizure tracing may be normal
Petit Mal	Usually between 4 and 8 years, rarely before 3 or after 15	Simple staring (most frequent) Staring with clonic movements Staring with automatisms	Always brief (momentary)	Daily, frequently as many as 50 to 100 per day	Diffuse, bilaterally synchronous spike and wave forms usually recurring at frequency of 3 per second
Psychomotor (temporal lobe)	Most commonly in older children and adults	Manifestations vary considerably, most commonly automatisms consisting of staring episodes with smacking of lips, chewing movements, mumbled speech; confused states, bizarre motor and/or psychic performances	Usually lasts several minutes or so	Daily in many patients	Epileptiform discharges, usually spikes, from the anterior temporal areas in most patients, particularly in the older child and adult. In some patients, the EEG reveals other types of electrical abnormalities; occasionally interseizure tracing is normal
Myoclonic Infants	During the first year of life, most commonly between 3 and 9 months	Flexor spasm of musculature resulting in massive myoclonic seizure in recumbent position, and head dropping attack in sitting position, extensor spasm of musculature occurs less often	Individual spell very brief, several seconds or so, spells frequently recur in clusters lasting several minutes	Usually daily	Hypsarhythmia
Myolconic Older Children	After 2 years of age, most commonly between 3 and 7 years	Flexor spasm of musculature resulting in head dropping attack when mild, and precipitous fall forward when severe; extensor spasm of musculature occurs less often	Very brief, several seconds or so	Daily, weekly	Modified hypsarhythmia

Note. From S. Livingston, *Comprehensive management of epilepsy in infancy, childhood and adolescence*, 1972. Reprinted Courtesy of Charles C Thomas, Publisher, Springfield, Illinois.

* This classification is currently employed at the Samuel Livingston Epilepsy Diagnostic and Treatment Center.

** By nonspecific, we mean electroencephalographic abnormalities other than (1) the classic diffuse, bilaterally synchronous spike-wave forms which usually recur at a frequency of 3 per second, and (2) hypsarhythmia. These two electrical abnormalities are, in our experience, found in essentially all patients with petit mal epilepsy and myoclonic epilepsy, respectively. Electrical abnormalities, usually consisting of spikes, localized to the anterior temporal areas are relatively specific for psychomotor (temporal lobe) epilepsy. These electrical aberrations are occasionally observed in the electroencephalograms of patients who present clinical evidence of other types of epilepsy, particularly major motor epilepsy.

The following is a description of an asthmatic attack:

> "The difficulty in breathing experienced during an asthmatic attack is the result of swelling of the membranes and constriction of the muscles in the breathing tubes, the bronchi, which leads to the lungs. The victim is then forced to wheeze in attempts to get air into the lungs. The swollen membranes then produce a sticky liquid which further increases the difficulty in breathing." (Gillie and Merier, 1978, p. 144)

Treatment for asthmatic conditions will vary depending upon the severity of the asthma. Treatment may include the use of medication, an inhalator, postural drainage, or breathing exercises to induce relaxation. If a student is asthmatic, the physician and/or parents should inform the teacher of the appropriate action to take. Asthmatics are also prone to getting bronchitus and should try to avoid people suffering from influenza or colds.

Ingestion of Poisons

It is critical that all substances such as cleaning fluids, disinfectants, and medications be securely locked up for storage in the classroom. Should an accident occur in which the ingestation of a toxic substance takes place, immediate action is necessary. Either an antidote or an emetic will be required, depending upon whether or not the poison is corrosive or non-corrosive and should be brought up out of the child's system. (If possible, have available a chart indicating counterdoses.) A physician should be contacted immediately.

Choking

It is likely that there may be severely multiply handicapped students who lack basic skills in eating. If a child is having difficulty in breathing while eating or drinking, actions must immediately be taken to prevent choking. Symptoms of choking include alarming attempts at inhalation, holding hand to the throat, discoloration of face, neck, or hands, cessation of breathing, or unconsciousness. In addition to an obstruction occurring within the food passage, the swallowing of inedible objects or liquids may induce aspiration in the larynx or lower air passages. In both cases, allow the child to assume a comfortable position and encourage him or her to cough in an attempt to clear the passage. If this is not successful, other emergency first aid actions must be taken. Refer to any current first aid and personal safety manual for specific instructions on these procedures (e.g. Heimlich).

Sunburns

Some students have extremely sensitive skin and may be highly susceptible to sunburns. Some medications will cause or increase this sensitivity. Precautionary measures must be taken prior to the student spending any extended time out of doors. These might include the use of more protective clothing, a hat, or some type of sun screen lotion.

There are many other problems which a teacher and staff should be medically prepared to handle in the classroom; these may include shock, nosebleeds, poor circulation, high temperatures, minor cuts or swellings, or foreign materials in the eyes, ears or nose. These situations will not be further discussed here; however an emergency care or first aid manual will provide the needed information to deal with these situations.

A third aspect of being prepared to handle emergency situations in the classroom is to formulate a specific plan of action that all the staff is aware of. It is important to obtain written information indicating the following: parents' home and work numbers' emergency telephone numbers; alternate contact person; name and phone number of child's primary care physician; current medications, if any; and parent authorization for school personnel to seek emergency medical treatment in the event that the responsible party cannot be reached. This information should either be posted or made otherwise easily accessible in the classroom. It must also be determined who is going to be responsible for keeping the information current and who is going to contact these persons in an emergency situation.

By preparing in advance for an emergency situation, actions by the staff will be conducted more quickly and more effectively. There will be less "panicking" by those persons involved. It is essential that a plan be developed and for each staff member to know in advance what needs to be done should a crisis occur.

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Self-Quiz #1

1. List at least 4 examples showing how personal hygiene can be practiced in the classroom.

2. List 5 areas where particular attention is needed as part of general classroom hygiene.

3. List 2 functions of a health check:

   1.

   2.

4. If there is no school nurse available to administer a student's medication, the teacher may automatically assume responsibility for administering it.

   TRUE FALSE

5. Which of the following is not one of the guidelines recommended by the Committee on School Health for administering medications?

   a. Written orders from a physician
   b. Written permission from the parents requesting the school district to comply with the physician's order.
   c. Only one member of the staff should be designated to handle the task
   d. Medication should be in a container that is properly labeled.
   e. None of the above

6. Identify 3 areas which will facilitate advance preparation of the staff for better handling of an emergency situation.

7. The most serious type of seizure in the classroom which requires immediate attention is:

   a. petit mal
   b. major motor
   c. psychomotor
   d. myoclonic

8. List some of the reactions exhibited by a child after awakening from a seizure.

9. ________________________ are typically manifested as a sudden brief loss of consciousness and may sometimes be mistaken for "daydreaming".

10. List at least 6 possible health problems or emergency situations which may require medical attention in the classroom.

Teacher-Professional Interrelationships

Lesley Fernandez

Most descriptions of classrooms for the severely multiply handicapped include mention of a transdisciplinary team approach: a group of people, each competent in specific areas, sharing skills and working together for the benefit of the student. (See Lyon & Lyon, Module 3 for more information on the transdisciplinary approach.) Even in classrooms where the team approach isn't used, teachers are having more and more contact with other professionals, i.e. doctors, nurses, social workers, occupational therapists, physical therapists, speech clinicians, etc. According to Sailor and Haring (1978), a competent teacher of the severely/profoundly handicapped must have the "ability to communicate and cooperate with members of other relevant disciplines.."(p. 18). Unfortunately, there are few guidelines on how to do this. This article will address the teachers' relationship with other professionals in the areas of referral, both for medical and educational evaluations, and follow-up.

Often the teacher, rather than the parent, is the initiator of most referrals (Valletutti, 1975). The teacher must walk a fine line between identifying behaviors which actually signal the need for a referral, and using the referral as a means of giving a problem to someone else, i.e. if John's toileting program is not effective after a few weeks, he does not necessarily need to be referred to a urologist. Figure 1 illustrates a sample referral form.

Most referrals fall into one of the following 7 categories: 1) health related; 2) visual; 3) hearing; 4) learning; 5) behavioral and emotional; 6) speech; and 7) home related (Long & Frye, 1977). Generally, each school district has a specific referral system. It is the responsibility

REFERRAL FORM

Referred to:

Student Name ______________________________ Date ____________________

Age ___________ Address ____

Referred by ____

Referral approved by parents: Yes __________ No ______________

Parent Signature: _______________________________________

Reason for referral:

Based upon: Observation
(describe) Assessment
Informal testing
Parental referral
Copy included _____________

Possible environmental/external factors that could be contributing factors:

Other channels teacher has tried: Result:

Figure 1

of the teacher to learn what that system consists of, although the following general guidelines should be followed.

1. Be as specific and precise as possible. Note what the student is doing or not doing, where he does it, when he does it, etc. Include any program data that could back up your referral. Often, informal assessments (see module 5) are help for referrals. Figure 2 provides an example of an informal assessment that could be used as the basis for a referral to an OT.
2. Be aware of who, what, where, and how much an outside consultation (if necessary) could cost. This could help speed up the referral system. Figure 3 provides an outline of professional evaluative responsibilities.
3. Consult with the parent. Many school districts require parental written permission, even for an evaluation by another discipline within the district.
4. Follow your school district's procedures.
5. Keep written records of all information. This should include the date you initiated the refe[illegible], all contacts you've had with the consultant or physician (including written summaries of phone calls or conversations), and copies of information you provided to the consultant as your basis for referral. You would also want to update the student's STEP file, whether it be a medication change, an adaptive equipment change (if, for example, the orthopedist ordered braces), or an additional program (the OT doing tendon stretches).
6. Ask that you be given a copy of any procedures, or services recommended.
7. Cffer any assistance; you work with the student six hours per day and can offer valuable information.

Once the referral and ensuing evaluation have been completed, the teacher will generally be responsible for some type of follow-up report. If it was a medical evaluation, the teacher should monitor whether the medication or treatment had effect on the student's educational performance (Holvoet, Note 1). If it was an educational evaluation, i.e. PT, OT, or speech, then again the teacher must either monitor the effect of the treatment on the student's educational performance or must work with the consultant on follow-up activities. Figure 4 illustrates an example of a medical follow-up monitoring sheet. In this example, the student

INITIAL FEEDING ASSESSMENT

CHILD'S NAME ______________________ ASSESSMENT DATE __________

I. What type of foods does the child eat? Pureed ______, Junior ______, Table ______.

II. What type of cues are used with the child?

III. LIPS

Does the child lose food through lips: Yes ____ No ____.
Retracts lips easily: Yes ____ Difficulty ____ No ____.
Holds lips together normally: Yes ____ No ____.
Does child pull food off of spoon with lips: Yes ____ No ____.

IV. TONGUE

What type of movement occurs with the food once it is in the mouth?

V. CHEWING

Does child bite off with the front teeth: Yes ____ No ____.
What type of motion occurs: Rotary ____ Up and Down ____.
Is food chewed or does the tongue mash it?

VI. DRINKING -- Write Comments

VII. ADDITIONAL COMMENTS:

Figure 2

From Thomas, E.D. and Marshall, M. J. Clinical evaluation and coordination of services: An ecological model. Exceptional Children, 1977, 42 (1),

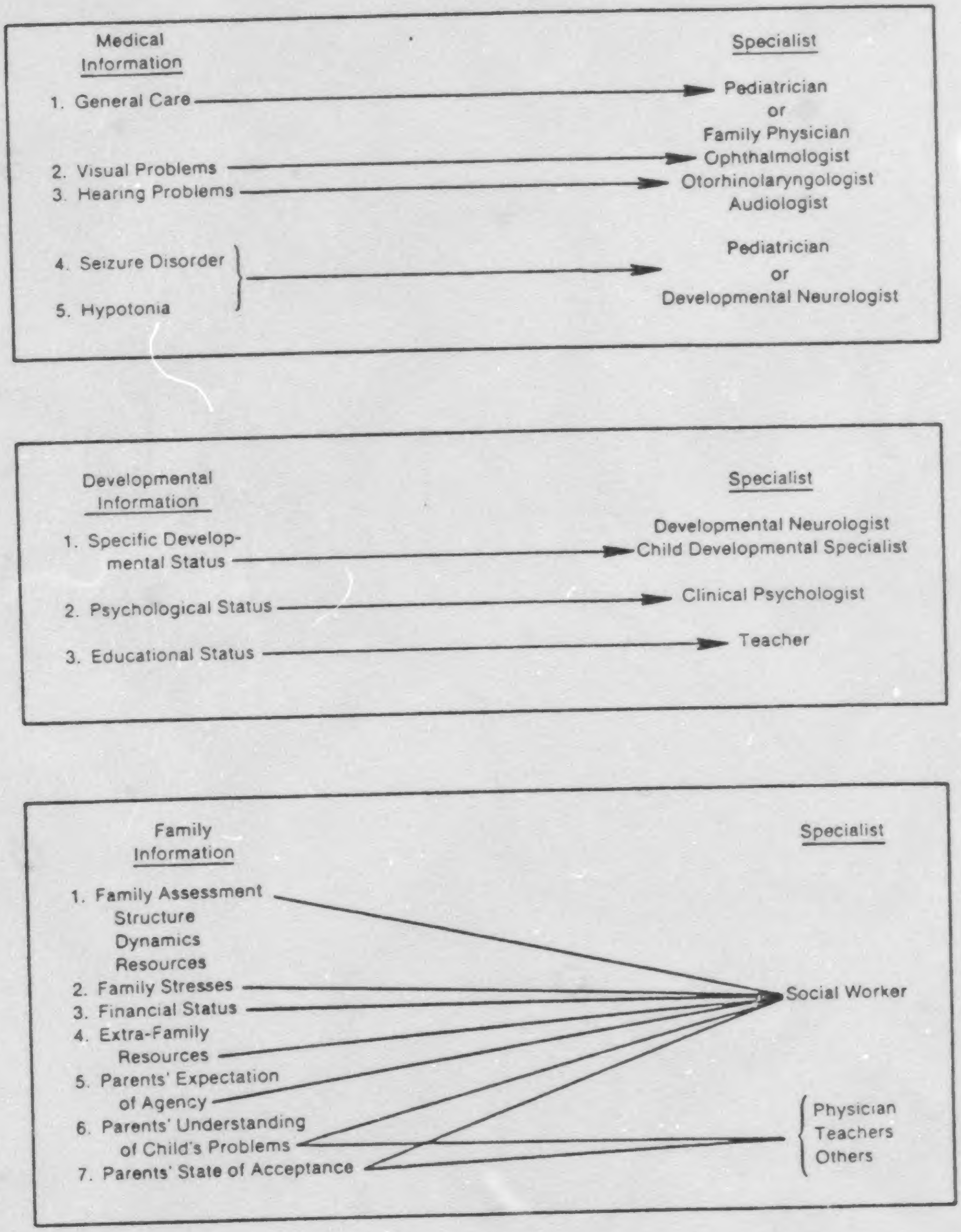
Medical Information
Specialist
1. General Care
Pediatrician or Family Physician
2. Visual Problems
Ophthalmologist
3. Hearing Problems
Otorhinolaryngologist Audiologist
4. Seizure Disorder
5. Hypotonia
Pediatrician or Developmental Neurologist
Developmental Information
Specialist
1. Specific Developmental Status
Developmental Neurologist Child Developmental Specialist
2. Psychological Status
Clinical Psychologist
3. Educational Status
Teacher
Family Information
Specialist
1. Family Assessment Structure Dynamics Resources
2. Family Stresses
3. Financial Status
4. Extra-Family Resources
5. Parents' Expectation of Agency
6. Parents' Understanding of Child's Problems
7. Parents' State of Acceptance
Social Worker
Physician Teachers Others

Figure 3

Akinetic Seizure Monitoring Sheet

Student John Doe
Month July Year 1980

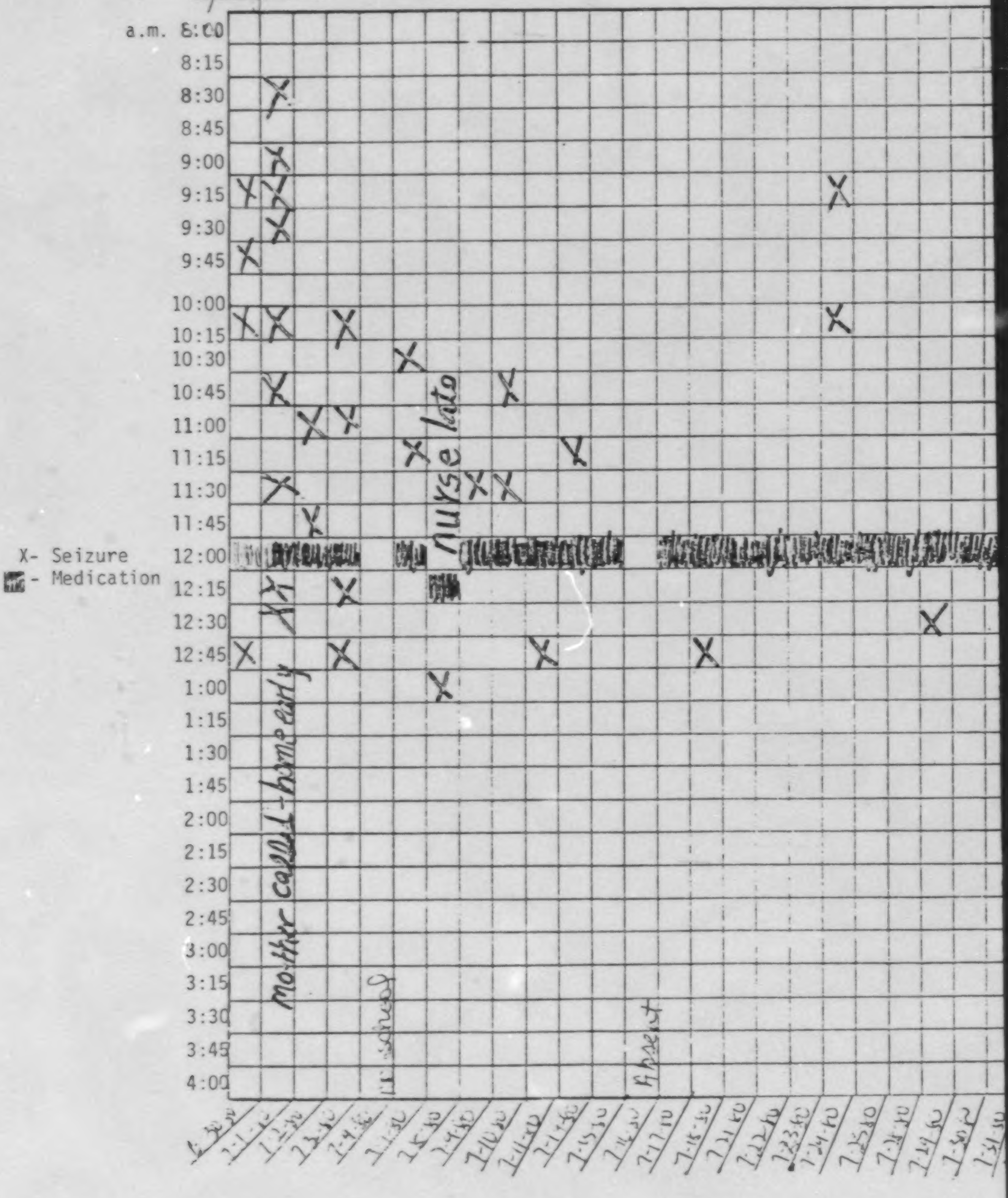

Figure 4

was seen by a neurologist and medication was prescribed for akinetic (drop) seizure control. The teacher was asked to monitor the student during the school day to see if the medication was indeed controlling the seizures. (The monitoring sheet also served as a reminder that the school nurse was to administer the medication at noon.) Figure 5 is an example of an educational follow-up. In this example the OT began providing direct services to the student (stretching heel cords and tendons) as a result of the referral. The therapist then wanted to see if his/her direct services were changing the student's classroom ambulation skills so the teacher provided the classroom program data.

A copy of the student's program graph would also serve the same purpose. Neither of these follow-ups require excessive teacher time, yet they can provide invaluable information for the physician/therapist.

The teacher and the consultant must work together for the benefit of the student. Iacino and Bricker (1978) outline three areas in which the teacher of the severely handicapped must work with consultants as a synthesizer of information. The first area is that of acquiring and evaluating the information of the consultant. This includes determining the appropriateness of the consultant's evaluation instrument. Frequently, consultants have had very little exposure to the severely handicapped population. The teacher may have to provide some appropriate alternative evaluation instruments. In this case, the teacher is acting as a consultant to the consultant.

The second area in which the teacher and the consultant must interrelate is in the area of direct services. As special education enrollments increase, therapists are unable to provide direct services to all students. The teacher and the consultant must determine instances where the teacher or classroom staff could implement the services. This would depend of course, upon the teacher's/classroom staff's skill levels and avail-

OT Weekly Monitoring Sheet

Student John Doe

Date: 12/8/80	Program data: 3 steps/min. Comments: school bus late - short session 5 min.
Date: 12/9/80	Program Data: 12 steps/min. Comments: 15 minutes
Date: 12/10/80	Program data: 10 steps/min. Comments: 15 minute session
Date: 12/11/80	Program data: 12 steps/min. Comments: 20 minute Session
Date: 12/12/80	Program data: 9 steps/min. Comments: John crying most of session. Shoes feet checked but OK. Short session - 5 minutes

Figure 5

able time. For example, the teacher (if skilled or taught the skills by the consultant) could assume the responsibility of an oral stimulation program, freeing the therapist for direct services to another student. A note of caution is urged to all teachers when providing these services. The teacher should NOT attempt services which he/she is not qualified for, i.e. increasing a student's range of motion by applying pressure to a joint. The teacher could do more harm than good.

The third area of teacher and consultant information synthesis is that of encouraging the consultants to accept and use the information that the classroom staff have. This requires tact, precision, diplomacy and courtesy on both the part of the teacher and the consultant. According to Iacino and Bricker (1978), by adopting this approach:

> "...pediatricians could gain valuable input for medical histories, physical therapists could gain more information on a range of motion in various settings and positions, and communication specialists could use classroom data on vocalizations and/or alternative communication systems. Careful documentation of classroom behavior will help prepare the teacher to offer useful information. Readiness with accurate, well documented information might also encourage therapists to continue to seek the staff's input." (page 70)

These three areas illustrate the teacher and the consultant maintaining a two-way flow of information (Teacher ⇄ Consultant) rather than a dead-end flow of information (Teacher ⟶ Consultant or Consultant ⟶ Teacher). They must work together to synthesize all information into a comprehensive, cohesive program for the benefit of the student.

Reference Notes

1. Holvoet, J. Medical aspects: The teacher-physician team. Presented at Kansas University Medical Center, Kansas City, Kansas, October, 1979.

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Sailor, W., & Haring, N. Progress in education. In D. Bricker & N. Haring (Eds.) Teaching the severely handicapped, Volume III. Columbus, OH: Special Press, 1978, 1-33.

Thomas, E., & Marshal, M. Clinical evaluation and coordination of services: An ecological model. Exceptional Children. 1977, 42, (1), 173.

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Self-Quiz #2

1. Which of the following is not a general area of referral:

   a. learning
   b. speech
   c. myelination
   d. visual

2. When describing why they are referring a student, a teacher should be as ____________________ as possible.

3. Explain why a teacher should determine the appropriateness of the consultant's evaluation instrument.

4. Explain why a physician would be interested in a teacher's follow-up report. Give one example of when a follow-up report would be advantageous.

5. The teacher, rather than the parent, is the initiator of most referrals.

   TRUE FALSE

Two Special Topics:

The Deaf-Blind Student and The Abused Child

Lesley Fernandez

Introduction

All students must be dealt with on an individual basis. Certain handicaps or situations however, require extra consideration. Just as the physically handicapped have special needs (Welch & Baker, Note 1), so do abused students and the sensory handicapped, i.e. deaf-blind students. This chapter examines some of the needs of the deaf-blind student and the teacher's responsibility to the abused student.

Deaf-Blind

Kansas currently classifies the severely/multiply handicapped and the deaf-blind student as one area of exceptionality. This is because hearing and visual handicaps are frequent manifestations of other syndromes. Table 1 (Black & Nagel, 1975; Gellis & Feingold, 1968) presents syndromes in which partial or total deafness and partial or total blindness are common.

The state defines deaf-blind students as:

> "Students who have auditory and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot properly be accommodated in special education programs solely for the hearing handicapped child or for the visually handicapped child. Although the deaf/blind have many of the same learning characteristics and needs as the severely multiply handicapped, they may not always be functionally severely or profoundly retarded." (K.S.D.E., 1980, p.1)

In practical terms, a student is certified deaf-blind only when he/she:

1. Has any one or more of the following visual problems:
    a. Measured or estimated corrected vision of 20/100 or less in the better eye, or:
    b. Certified cortical blindness, or:

Table 1

Syndrome	Visual Disorders*																	Auditory Disorders	
	nystagmus	vision loss	retinitis pigmentosa	cataracts	colobomas	megalocornea	corneal degeneration	strabismus	lenticular calcification	hypertelorism	exophthalmus	optic atrophy	ptosis	glaucoma	anophthalmis	microphthalmia	blind	partial hearing loss	deafness
Metaphysical Dysplasia	X	X															X	X	
Chromosome 18	X									X									X
Hunter's			X															X	X
Crouson's	X							X		X	X								X
Hurler's				X	X	X	X										X	X	
Osteopetrosis				X								X					X	X	X
Mucopolysacchairdosis				X													X	X	X
Ring Chromosome 18								X					X					X	X
Kernicterus	X																	X	X
Rubella				X										X			X	X	X
Albright's Hereditary Osteodystrophy				X				X	X								X	X	
Syphilis Congenital												X					X	X	X
Ocular-Cerebro-Renal			X														X		X
Turner's								X					X				X		X
Patau's															X	X	X		X

* Appendix A contains a glossary of terms related to visual problems.

   c. A field of vision that is 20° or less in the better eye, or:
   d. Visual acuity that cannot be measured and the student is suspected of being "functionally blind", i.e. the student does not visually track, localize or use his/her vision appropriate to the student's developmental level.

2. The student must also exhibit either of the following hearing problems:

   a. A minimum 30 db bilateral sensory-neural hearing loss across the speech frequency in the better ear with amplification, or:
   b. Sensitivity and middle ear functioning cannot be definitively measured and the student is suspected of being "functionally deaf", i.e. the student does not auditorally attend to, respond to, or localize sounds, or use his/her hearing appropriate to the student's developmental level.

(Maher, 1978a, 1978b)

As indicated by the definitions above, a student certified as deaf-blind is not necessarily totally blind or totally deaf. In fact, generally less than 15% of a deaf-blind population are truly deaf-blind (de Leuw, Note 2). The rest of the population will have some residual hearing, some residual vision, or a combination of both. This, combined with the fact that there are presently no totally accurate methods of evaluating a handicapped student's vision or hearing, indicate that care must be taken not to reduce the visual or auditory stimulation in a deaf-blind student's environment. In other words, simply because a student is labeled 'deaf-blind' does not mean that an educator should not used auditory cues and explanations or use visual stimuli. (For the purposes of this chapter, 'deaf-blind' will indicate a student who could be certified as such.)

In order to teach a deaf-blind (total or partial impairments) student, an educator must look at how this student differs from the sighted and hearing student. There are two major areas in which the deaf-blind student is at a disadvantage; 1) communication, and 2) environmental interactions and relationships.

Communication

Communication is a deficit area for deaf-blind students just as it is a deficit area for all hearing handicapped students. Obviously, if a student has trouble hearing words, he/she is going to have trouble acquiring verbal language. This is generally dealt with by augmenting the language system in the visual field, i.e. reading lips, reading manual signs, or reading communication symbols (words, pictures, geometric figures, etc.).

Unfortunately, the deaf-blind student is denied these visual augmentations. Even when the student has only a partial sight loss, the visual restrictions demand that the educator go one step further in augmenting the communication system. The remaining sensory modes are those of touch, taste, and smell. Ruling out taste and smell as nonfunctional communication modes for most environments (these sensory modes can be used in very structured environments as program S^{D}'s which later can be faded out), the educator is left with the tactile sense.

The type of tactile augmentation chosen will depend on what communication mode a particular student is using. The three most common communication modes are:

1. Oral (speech)
2. Manual (sign language, fingerspelling, or gestures)
3. Symbolic (communication boards, communication symbols, etc.)

Oral. The most common tactile augmentation for an oral communication mode is the vibration or Tadoma method. This is where the student's hand is placed on the speakers neck/mouth to feel the vibrations and various lip movements. There are five hand positions for the vibration system:

1. Thumb on or below the speaker's lips with the fingers spread on the cheek and upper neck.

2. The two thumbs placed over the lips extending from the chin to the upper lips, the fingers spread out fanwise across the cheeks reaching down to the neck.

3. Two hands, one on the lips and cheek and the other hand on the neck and cheek.

4. Two hands, one hand on the speaker's face and one hand on his own face so he can compare his own vocal output with that of the speaker.

5. A deaf child with some sight can place the thumb on the side of the speaker's mouth or just below the lower lips instead of directly on the lips, thus enabling him to visually speech read as well as gain supplementary tactile clues.
(Howard, 1973, p. 16)

Figure 1 illustrates hand positions for vowel sounds and the diphthongs.

Manual. Augmenting a manual communication mode using the sense of touch means that the student must 'feel' the communication movement, whether it be an informal manual mode such as gestures, or a formal mode such as finger spelling. Expressively, there need not be any contact between the student and the educator, as the educator can see the student's movements. Receptively, there must be contact. This contact can be made on the student's body or away from the student's body with his/her hands following the manual movement. Figure 2 illustrates the differences between a contact system (manual sign made on the student's body) and a formal sign system (the student follows the gesture/sign with his/her hands). (Costello, 1973).

A note of caution is urged when teaching a deaf-blind student using any of the manual systems. Having the student feel the sign, whether on his/her body or away does not mean that the student has a 'picture' of the sign, or that the student could duplicate the sign or gesture expressively. This generally requires many, many repetitions of the student being put through the expressive sign or gesture movement. The teacher will also need to teach the association between the concrete and the language symbol movement, i.e. a sock and the sign for sock, for both the expressive and receptive sign movements. An example (see Figure 3) would be the sign for 'comb'. Expressively, the student must flex his/her arm, raising it to head level, while receptively, the student must extend his/her arms to another person's head-yet, these two movements signal the same concrete object.

Symbolic. Augmenting a symbolic communication mode with tactual symbols is probably the easiest adaptation to make. Instead of using visual symbols, i.e. letters, pictures, bliss symbols, or words, the educator uses tactual symbols, such as different textures, raised letters, or braille. The two can be combined, i.e. the round piece of sandpaper that is a symbol for ball can be labeled with the word 'ball'. This makes the communication system more functional for persons outside the classroom.

There are no specific techniques for teaching a communication system to a deaf-blind student, just as there are no specific techniques for teaching a communication system to any other handicapped student. Each student's needs must be looked at individually. The basic rules for communication training are the same (see Module 17) for all students, only the sensory deprivations of the deaf-blind student require some adaptations in the educator's teaching methods.

Environmental Interactions and Relationships

Hearing and vision are often called our "distance senses", (de Leuw, Note 2). It is primarily through these two senses that our environment expands beyond our fingertips. However for the deaf-blind student, these two senses are severely deficit. This limited environment affects all areas of the deaf-blind student's development. The normally sighted and

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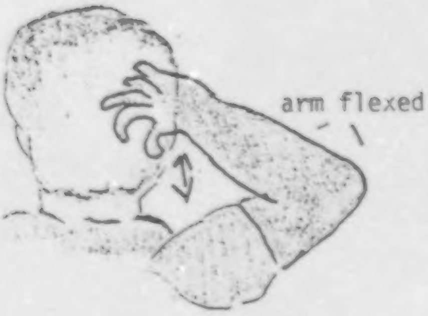
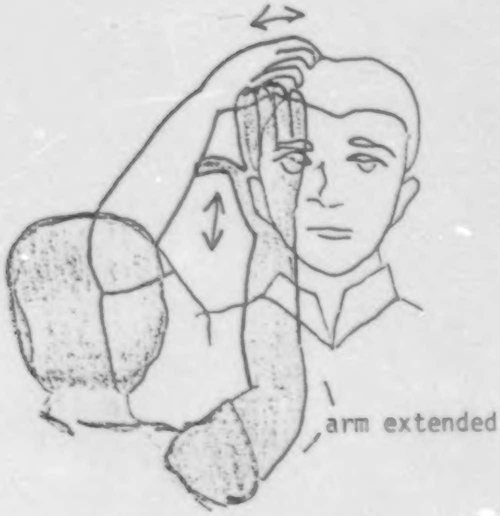
SIGN MOVEMENTS

EXPRESSIVE



Student expressively using sign for comb

RECEPTIVE

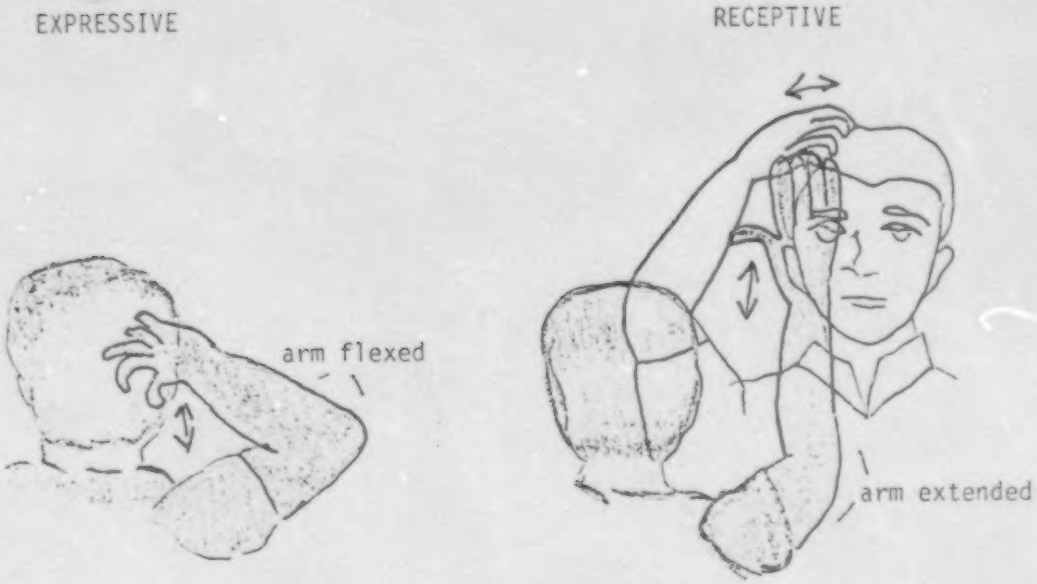

arm extended

Student receptively reading sign for comb

* Student body parts are shaded for better illustration

Figure 3

SIGN MOVEMENTS


EXPRESSIVE
RECEPTIVE
arm flexed
arm extended

Student expressively using sign for comb

Student receptively reading sign for comb

* Student body parts are shaded for better illustration

Figure 3

hearing child will lift his/her head to look at his/her mother, will pull him/herself along the sofa to reach the bright toy, will manipulate the string on the pull toy when hearing the music, or look for the toy after dropping it. The deaf-blind student is deprived of these learning stimuli and therefore is generally delayed in motor areas, cognitive areas, social areas, self-help areas, etc.

The teacher of the deaf-blind student must try to expand the student's environment, using as many sensory modes as necessary. The skills taught to a deaf-blind student may not differ from the skills taught to a normal sighted/hearing student, however the teaching methods and materials probably will. The following are some basic guidelines that the teacher of a deaf-blind student should follow:

1. Keep the environment as consistent as possible; do not rearrange the classroom simply because you're tired of it the way it is. This involves careful planning at the beginning of the school year, as the mobility needs of the deaf-blind student must be taken into consideration. For example, if your student must trail (using the back of the hand to 'trail' environmental landmarks), then you must design your classroom with identifiable pathways, i.e. the solid brick wall leads to the classroom, the tiled wall leads to the bathroom, the wooden divider leads to the eating area, etc. Once the student has learned these pathways, they should not be changed on teacher 'whim'.

2. Define the student's work area, whether it is a large area for gross motor activities or a desk-sized area for fine motor activities. For example, during a gross motor program, where large space is required, the area could be defined by dividers or mat edges. A small area could be defined by a lipped desk edge. By controlling the amount of environment the student must respond in, you increase the chances that the student will independently respond.

3. Make sure you're aware of any environmental obstructions. Just because you duck autonatically for low-hanging mobiles, it doesn't mean that the student will. A good idea is to put yourself through the student's daily movements, keeping your eyes shut. You will probably discover that your classroom is not obstructionally clean.

4. Evaluate all materials. Are they discriminable as is or do they need to be adapted? Remember that visual and auditory cues must be supplemented. Again, put yourself in the student's place. Can you discriminate by touch the difference in the two soft plastic squeeze toys? Is there that much difference between the round plastic glass and the round plastic shampoo bottle?

5. Remember that touch is the deaf-blind student's major sensory input mode. Allow the student to feel his materials and his environment. If the student doesn't use his/her sense of touch, teach the skill. For example, if you are trying to teach a student to discriminate between objects, your program must allow the student to feel all objects before a discrimination can take place. Otherwise, the student will not know what choices he/she has.

The supplementary reading list contains additional resources for further information about hearing and vision handicaps.

Floyd McDowell (1973), Director of the deaf-blind program in Wyoming states that a teacher of the deaf-blind must:

1. Free his/her thoughts of philosophical or methodological confinement or prejudice.
2. Evaluate each child individually in terms of where he is; what immediate attainable goals are; what his strengths and weaknesses are.
3. Plan, record, revise and be consistent in your individualized programs.
4. Use all the methods, tools or procedures available to us in the profession.
5. Don't be afraid to use your imagination and inventiveness. The best ideas in teaching come from the classroom teacher.

Child Abuse

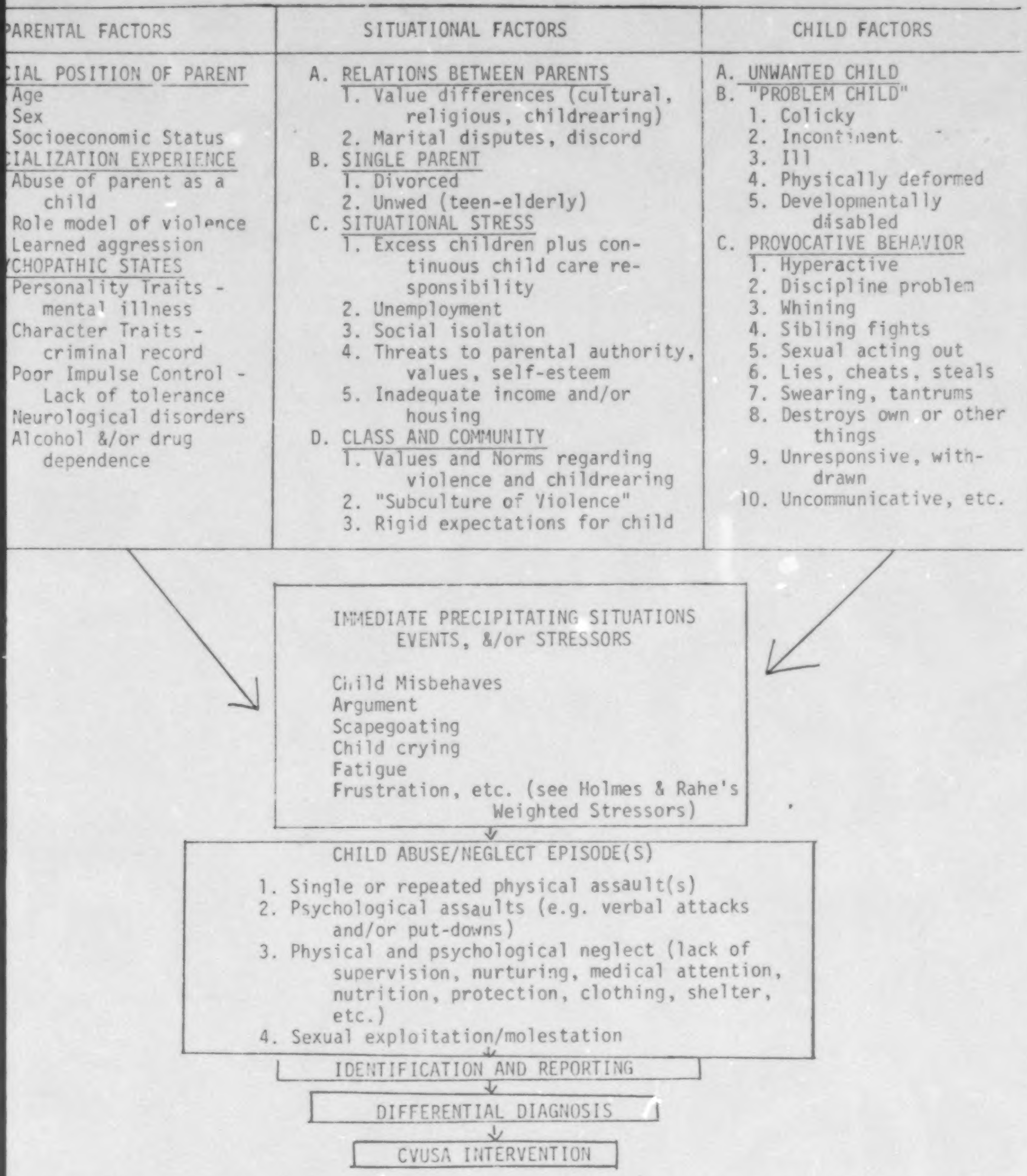
"Surveys (such as the American Humane Association's National Study), various research studies and other efforts to estimate the extent of abuse and neglect indicate that there are between one and two million new cases in the United States each year..." (CVUSA, 1979, page 4).

Unfortunately, studies are now indicating that mental retardation/ physical handicaps can be contributing factors to child abuse (see Figure 4 and 5). Therefore, special educators should be aware of their legal responsibilities.

The Kansas Child Protection Act mandates teachers to report suspected child abuse/neglect. A handbook is available from local SRS offices. This handbook, The Educator's Role in the Prevention and Treatment of Child Abuse, outlines signs that could indicate possible child abuse and neglect. Teachers should report their suspicions as quickly as possible and not take time to investigate; investigation is the responsibility of the assigned case worker (Griegs, note 5). Generally most school districts require a teacher to first report his/her suspicions to the school principal. However, the teacher's responsibilities do not end there. It is possible, for example, for a teacher to only report the suspicions to the principal. The principal however might not pursue the matter (i.e. contact the local SRS office of the county). If the abuse case then came to the attention of the authorities from another source, the teacher could be held legally responsible for not reporting the suspected child abuse or neglect (Griegs, note 5).

In Kansas, a teacher who does not report his/her suspicions of abuse or neglect can be found guilty of a Class B misdemeanor, which carries a

MULTIFACTORIAL MODEL FOR CAUSATION OF CHILD ABUSE AND NEGLECT



PARENTAL FACTORS

CIAL POSITION OF PARENT
- Age
- Sex
- Socioeconomic Status

CIALIZATION EXPERIENCE
- Abuse of parent as a child
- Role model of violence
- Learned aggression

CHOPATHIC STATES
- Personality Traits - mental illness
- Character Traits - criminal record
- Poor Impulse Control - Lack of tolerance
- Neurological disorders
- Alcohol &/or drug dependence

SITUATIONAL FACTORS

A. RELATIONS BETWEEN PARENTS
   1. Value differences (cultural, religious, childrearing)
   2. Marital disputes, discord

B. SINGLE PARENT
   1. Divorced
   2. Unwed (teen-elderly)

C. SITUATIONAL STRESS
   1. Excess children plus continuous child care responsibility
   2. Unemployment
   3. Social isolation
   4. Threats to parental authority, values, self-esteem
   5. Inadequate income and/or housing

D. CLASS AND COMMUNITY
   1. Values and Norms regarding violence and childrearing
   2. "Subculture of Violence"
   3. Rigid expectations for child

CHILD FACTORS

A. UNWANTED CHILD

B. "PROBLEM CHILD"
   1. Colicky
   2. Incontinent
   3. Ill
   4. Physically deformed
   5. Developmentally disabled

C. PROVOCATIVE BEHAVIOR
   1. Hyperactive
   2. Discipline problem
   3. Whining
   4. Sibling fights
   5. Sexual acting out
   6. Lies, cheats, steals
   7. Swearing, tantrums
   8. Destroys own or other things
   9. Unresponsive, withdrawn
   10. Uncommunicative, etc.

IMMEDIATE PRECIPITATING SITUATIONS
EVENTS, &/or STRESSORS

Child Misbehaves
Argument
Scapegoating
Child crying
Fatigue
Frustration, etc. (see Holmes & Rahe's Weighted Stressors)

CHILD ABUSE/NEGLECT EPISODE(S)

1. Single or repeated physical assault(s)
2. Psychological assaults (e.g. verbal attacks and/or put-downs)
3. Physical and psychological neglect (lack of supervision, nurturing, medical attention, nutrition, protection, clothing, shelter, etc.)
4. Sexual exploitation/molestation

IDENTIFICATION AND REPORTING

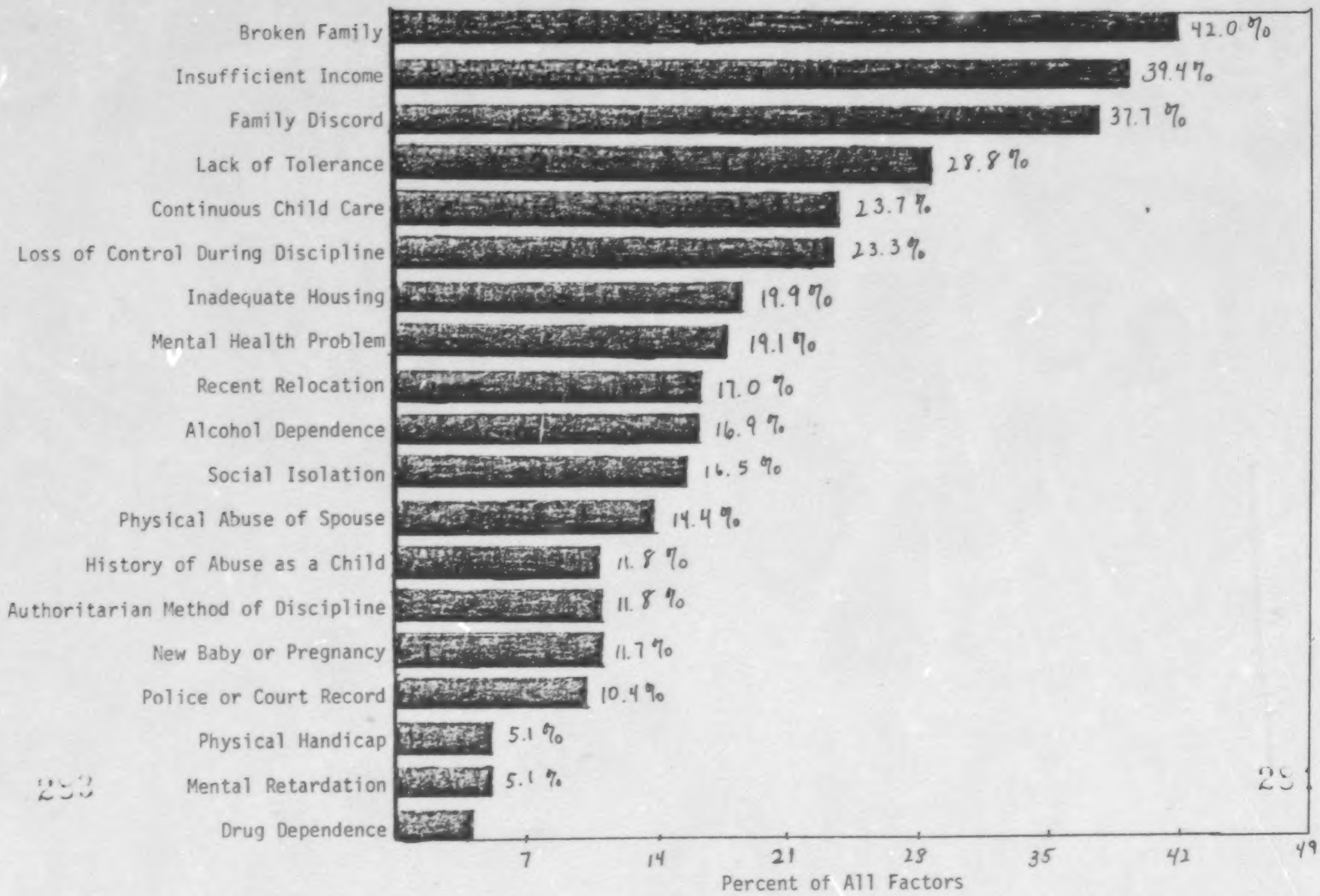
DIFFERENTIAL DIAGNOSIS

CVUSA INTERVENTION

Developed by Meier (1978). Derived in part from Gelles's Social Psychological Model of the Causes of Child Abuse, in Nagi (1978, p. 67), and augmented by findings of American Humane Study (1977) and Achenbach's Child Behavior Profiles (1978).

Figure 4 (Meier, Note 3)

AMERICAN HUMANE STUDY: FAMILY FACTORS PRESENT
(N=18,227 FAMILIES)



fine of $1,000.00 or six months in jail or both. The teacher can also be sued by the protective agency, a sibling or other family member.

Once the teacher has reported the suspected abuse/neglect, he/she should not assume that the student should be removed from his/her natural home, or that this is the only alternative. Aileen Griegs of the Kansas Department of Children and Youth (Note 5) states that only in severe cases are children removed from their natural home and then, only when the child is at risk. Otherwise, the case worker works with the family as a whole unit. Teachers have a legal and moral responsibility to report any suspected abuse or neglect.

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Appendix A

Vocabulary of Terms Relating to the Eye[1]

Accommodation–The adjustment of the eye for seeing at different distances, accomplished by changing the shape of the crystalline lens through action of the ciliary muscle, thus focusing a clear image on the retina.

Albinism–An hereditary loss of pigment in the iris, skin, and hair; usually associated with lowered visual acuity, nystagmus and photophobia and often accompanied by refractive errors.

Amblyopia–Dimness of vision without any apparent disease of the eye.

Amblyopia Ex Anopsia–Dimness of vision due to disuse of the eye.

Ametropia–A refractive error in which the eye when in a state of rest does not focus the image of an object upon the retina; includes hyperopia, myopia, and astigmatism. See Refractive error.

Aniridia–Congenital absence of the iris.

Aniseikonia–A condition in which the ocular image of an object as seen by one eye differs in size or shape from that seen by the other eye.

Anophthalmos–Absence of a true eyeball.

Anterior chamber–Space in the front of the eye, bounded in front by the cornea and behind by the iris; filled with aqueous.

Aphakia–Absence of the lens of the eye.

Aqueous–Clear, watery fluid which fills the anterior and posterior chambers within the front part of the eye.

Asthenopia–Eye fatigue caused by tiring of the internal or external muscles.

Astigmatism–Refractive error which prevents the light rays from coming to a single focus on the retina because of different degrees of refraction in the various meridians of the eye.

Binocular vision–The ability to use the two eyes simultaneously to focus on the same object and to fuse the two images into a single image which gives a correct interpretation of its solidity and its position in space.

Blepharitis–Inflammation of the margin of the eyelids.

Blindness–In the United States, the legal definition of blindness is: central visual acuity of 20/200 or less in the better eye after correction; or visual acuity of more than 20/200 if there is a field defect in which the widest diameter of the visual field subtends an angle distance no greater than 20 degrees. Some states include up to 30 degrees.

Buphthalmos–Large eyeball in infants–generally due to secondary glaucoma.

C, CC (Cum correction)–With correction, wearing prescribed lenses.

Canal of Schlemm–A circular canal situated at the juncture of the sclera and cornea through which the aqueous is excreted after it has circulated between the lens and the iris and between the iris and the cornea.

Canthus–The angle at either end of the slit between the eyelids; specified as outer, or temporal, and inner, or nasal.

Cataract–A condition in which the crystalline lens of the eye, or its capsule, or both, become opaque, with consequent loss of visual acuity.

Central visual acuity–Ability of the eye to perceive the shape of objects in the direct line of vision.

Chalazion–Inflammatory enlargement of a meibomian gland in the eyelid.

Chorioretinitis–Inflammation of the choroid and retina.

Choroid–The vascular, intermediate coat which furnishes nourishment to the other parts of the eyeball.

Choroiditis–Inflammation of the choroid.

Ciliary body–Portion of the vascular coat between the iris and the choroid. It consists of ciliary processes and the ciliary muscle. (See Uvea.)

Coloboma–Congenital cleft due to the failure of the eye to complete growth in the part affected.

Color deficiency–Diminished ability to perceive differences in color–usually for red or green, rarely for blue or yellow.

Concave lens–Lens having the power to diverge parallel rays of light, also known as diverging, reducing, negative, myopic, or minus lens, denoted by the sign –.

Cones and rods–Two kinds of cells which form a layer of the retina and act as light-receiving media. Cones are concerned with visual acuity and color discrimination; rods, with motion and vision at low degrees of illumination (night vision).

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[1] *Vocabulary of Terms Relating to the Eyes.* New York: National Society for the Prevention of Blindness, Inc., 1972.

Congenital–Present at birth.

Conjunctiva–Mucous membrane which lines the eyelids and covers the front part of the eyeball.

Conjunctivitis–Inflammation of the conjunctiva.

Contact or corneal lenses–Lenses so constructed that they fit directly on the eyeball; used for the correction of vision in cases having a cone-shaped cornea and for cosmetic reasons. Corneal lenses are also used after cataract (lens) extraction to replace the lens removed from the eye. They provide less distortion and image size difference from the other eye than spectacles would.

Convergence–The process of directing the visual axes of the two eyes to a near point, with the result that the pupils of the two eyes are closer together. The eyes are turned inward.

Convex lens–Lens having power to converge parallel rays of light and to bring them to a focus; also known as converging, magnifying, hyperopic, or plus lens, denoted by sign +.

Cornea–Clear, transparent portion of the outer coat of eyeball forming front of aqueous chamber.

Corneal graft–Operation to restore vision by replacing a section of opaque cornea with transparent cornea.

Crystalline lens–A transparent, colorless body suspended in the front of the eyeball, between the aqueous and the vitreous the function of which is to bring the rays of light to a focus on the retina.

Cyclitis–Inflammation of the ciliary body.

Cycloplegic–A drug that temporarily puts the ciliary muscle at rest and dilates the pupil; often used to ascertain the error of refraction.

Cylindrical lens–A segment of a cylinder, the refractive power of which varies in different meridians; used in the correction of astigmatism.

Dacryocystitis–Inflammation of lacrimal sac.

Dark adaptation–The ability of the retina and pupil to adjust to a dim light.

Depth perception–The ability to perceive the solidity of objects and their relative position in space.

Diopter–Unit of measurement of strength or refractive power of lenses.

Diplopia–The seeing of one object as two.

Duction–A stem word used with a prefix to describe the turning or rotation of the eyeball (abduction–turning out, adduction–turning in).

Dyslexia–Inability to read which is apparently due to a neurological problem.

Ectropion–An eversion or turning inside out of the eyelid.

Emmetropia–The refractive condition of the normal eye. When the eye is at rest, the image of distant objects is brought to a focus on the retina.

Endophthalmitis–Inflammation of most of the internal tissues of the eyeball.

Entropion–A turning inward of the eyelid.

Enucleation–Complete surgical removal of the eyeball.

Esophoria–A tendency of the eye to turn inward.

Esotropia–A manifest turning inward of the eye (convergent strabismus or crossed eye).

Exophoria–A tendency of the eye to turn outward.

Exophthalmos–Abnormal protrusion of the eyeball.

Exotropia–Abnormal turning outward from the nose of one or both eyes (divergent strabismus).

Extrinsic muscles–External muscles of the eye which move the eyeball. Each eye has four rectus and two oblique muscles.

Eye dominance–Tendency of one eye to assume the major function of seeing, being assisted by the less dominant eye.

Eye grounds–See Fundus.

Field of vision–The entire area which can be seen without shifting the gaze.

Floaters–Small particles consisting of cells or fibrin which move in the vitreous.

Focus–Point to which rays are converged after passing through a lens; focal distance is the distance rays travel after refraction before focus is reached.

Fornix–A loose fold of the conjunctiva where the part covering the eyeball meets the conjunctiva lining of the eyelid.

Fovea–Small depression in the retina at the back of the eye; the part of the macula adapted for most acute vision.

Fundus—The back of the eye which can be seen with an ophthalmoscope.

Fusion—The power of coordinating the images received by the two eyes into a single mental image.

Glaucoma—Increased pressure inside the eye; "hardening of the eyeball," caused by accumulation of aqueous fluid in the front portion.

Glioma—Malignant tumor of the retina.

Gonioscope—A magnifying device used in combination with strong illumination and a contact glass for examining the angle of the anterior chamber.

Hemianopsia—Blindness of one-half of the field of vision of one or both eyes.

Heterophoria—A constant tendency of the eyes to deviate from the normal position for binocular fixation, counterbalanced by simultaneous fixation forced by muscular effort (prompted by the desire for single binocular vision). Deviation is not usually apparent, in which case it is said to be latent.

Heterotropia—An obvious or manifest deviation of the visual axis of an eye out of alignment with the other eye. Syn. *cross-eye; strabismus.*

Hydrophthalmus (congenital glaucoma)—A rare congenital defect in which the eyeball is abnormally large. Iris present at birth or develops early in infancy.

Hyperopia, Hypermetropia—A refractive error in which, because the eyeball is short or the refractive power of the lens weak, the point of focus for rays of light from distant objects (parallel light rays) is behind the retina; thus accommodation to increase the refractive power of the lens is necessary for distant as well as near vision.

Hyperphoria—A tendency of one eye to deviate upward.

Hypertropia—A deviation upward of one of the visual axes.

Injection—A term sometimes used to mean congestion of ciliary or conjunctival blood vessels, redness of the eye.

Interstitial keratitis—Affection of the middle layer of the cornea; disease, found chiefly in children and young adults, is usually caused by transmission of syphilis from mother to unborn child.

Iridocyclitis—Inflammation of the iris and ciliary body.

Iris—Colored, circular membrane, suspended behind the cornea and immediately in front of the lens. The iris regulates the amount of light entering the eye by changing the size of the pupil.

Iritis—Inflammation of the iris; the condition is marked by pain, inflammation, discomfort from light, contraction of pupil, discoloration of iris. It may be caused by injury, syphilis, rheumatism, gonorrhea, tuberculosis, and so forth.

Ishihara Color Plates—A test for defects in recognizing colors, based on the ability to trace patterns in a series of multicolored charts.

Jaeger Test—A test for near vision: lines of reading matter printed in a series of various sizes of type.

Keratitis—Inflammation of the cornea; frequently classified as to type of inflammation and layers of cornea affected as "interstitial" keratitis or "phlyctenular" keratitis.

Keratoconus—Cone-shaped deformity of the cornea.

Keratoplasty—See Corneal graft.

Lacrimal gland—A gland which secretes tears; it lies in the outer angle of the orbit.

Lacrimal sac—The dilated upper end of the lacrimal duct.

Lacrimation—Production of tears.

Lagophthalmos—A condition in which the lids cannot be completely closed.

Lens—A refractive medium having one or both surfaces curved.

Light adaptation—The power of the eye to adjust itself to variations in the amount of light.

Light perception—(L.P.), ability to distinguish light from dark.

Limbus—Boundary between cornea and sclera.

Low-vision aids—Optical devices of various types useful to persons with vision impairment.

Macrophthalmos—Abnormally large eyeball, resulting chiefly from infantile glaucoma.

Macula lutea—The small area of the retina that surrounds the fovea and with the fovea comprises the area of distinct vision. Syn. *yellow spot.*

Megalophthalmos—Abnormally large eyeball present at birth (congenital).

Microphthalmos—An abnormally small eyeball present at birth (congenital).

Microscopic glasses—Magnifying lenses arranged on the principle of a microscope, occasionally prescribed for persons with very poor vision.

Miotic—A drug that causes the pupil to contract.

Mydriatic—A drug that dilates the pupil.

Myopia—Nearsightedness. A refractive error in which, because the eyeball is too long in relation to its focusing power the point of focus for rays of light from distant objects (parallel light rays) is in front of the retina. Thus, to obtain distinct vision, the object must be brought nearer to take advantage of divergent light rays (those from objects less than twenty feet away).

Near point of accommodation—The nearest point at which the eye can perceive an object distinctly. It varies according to the power of accommodation.

Near point of convergence—The nearest single point at which the two eyes can direct their visual lines, normally about three inches from the eyes in young people.

Near vision—The ability to perceive distinctly objects at normal reading distance, or about fourteen inches from the eyes.

Night blindness—A condition in which the sight is good by day but deficient at night and in faint light.

Nystagmus—An involuntary, rapid movement of the eyeball; it may be lateral, vertical, rotary, or mixed.

Oculist or ophthalmologist—A physician—an M.D.—who specializes in diagnosis and treatment of defects and diseases of the eye, performing surgery when necessary or prescribing other types of treatment, including glasses.

Oculus dexter (O.D.)—Right eye.

Oculus sinister (O.S.)—Left eye.

Oculus uterque (O.U.)—Both eyes.

Ophthalmia—Inflammation of the eye or of the conjunctiva.

Ophthalmia neonatorum—An acute, perulent conjunctivitis in the newborn; (for control purposes, it is sometimes legally defined as "an inflamed or discharging eye in a newborn baby under two weeks").

Ophthalmologist or oculist—See Oculist.

Ophthalmoscope—An instrument used in examining the interior of the eye.

Optic atrophy—Degeneration of the nerve tissue which carries messages from the retina to the brain.

Optic chiasm—The crossing of the fibers of the optic nerves on the lower surface of the brain.

Optic disk—Head of the optic nerve in the eyeball.

Optician—One who grinds lenses, fits them into frames, and adjusts the frames to the wearer.

Optic nerve—The special nerve of the sense of sight which carries messages from the retina to the brain.

Optic neuritis—Inflammation of the optic nerve.

Optometrist—A licensed, nonmedical practitioner, measures refractive errors—that is, irregularities in the size or shape of the eyeball or surface of the cornea—and eye muscle disturbances. In his or her treatment the optometrist uses glasses, prisms, and exercises only.

Orthoptic training—Series of scientifically planned exercises for developing or restoring the normal teamwork of the eyes.

Orthoptist—One who provides orthoptic training.

Palpebral—Pertaining to the eyelid.

Pannus—Invasion of the cornea by infiltration of lymph and formation of new blood vessels.

Partially seeing child—For educational purposes, a partially seeing child is one who has a visual acuity of 20/70 or less in the better eye after the best possible correction, and who can use vision as his or her chief channel of learning.

Perimeter—An instrument for measuring the field of vision.

Peripheral vision—Ability to perceive the presence, motion, or color of objects outside of the direct line of vision.

Phlyctenular keratitis—A variety of keratitis characterized by the formation of pustules or papules on the cornea; usually occurs in young children and may be caused by poor nutrition. Many physicians believe it to be a tubercular condition.

Phoria—A root word denoting a latent deviation in which the eyes have a constant tendency to turn from the normal position for binocular vision; used with a prefix to indicate the direction of such deviation (hyperphoria, esophoria, exophoria).

Photophobia—Abnormal sensitivity to and discomfort from light.

Pleoptics–A method of treating amblyopia through the use of instruments which restore fixation to the fovea by direct stimulation or by the production and correct localization of after-images.

Posterior chamber–Space between the back of the iris and the front of the lens; filled with aqueous.

Presbyopia–A gradual lessening of the power of accommodation due to a physiological change which becomes noticeable after the age of forty.

Prosthesis–An artificial substitute for a missing eye (or other missing part of the body).

Pseudoisochromatic charts–Charts with colored dots of various hues and shades indicating numbers, letters or patterns, used for testing color discrimination.

Pterygium–A triangular fold of growing membrane which may extend toward the cornea on the white of the eye. It occurs most frequently in persons exposed to dust or wind.

Ptosis–A paralytic drooping of the upper eyelid

Refraction–(1) deviation in the course of rays of light in passing from one transparent medium into another of different density; and (2) determination of refractive errors of the eye and correction by glasses.

Refractive error–A defect in the eye that prevents light rays from being brought to a single focus exactly on the retina.

Refractive media–The transparent parts of the eye having refractive power; cornea, aqueous, lens, and vitreous.

Retina–Innermost coat of the eye, formed of sensitive nerve fibers and connected with the optic nerve.

Retinal detachment–A separation of the retina from the choroid.

Retinitis–Inflammation of the retina.

Retinitis pigmentosa–An hereditary degeneration and atrophy of the retina. There is usually misplaced pigment.

Retinoblastoma–The most common malignant intraocular tumor of childhood occurs usually under age five. It is probably always congenital. (Formerly known as glioma).

Retinopathy–A disease of the retina, due to various causes.

Retinoscope–An instrument for determining the refractive state of the eye by observing the movements of lights and shadows across the pupil by the light thrown onto the retina from a moving mirror.

Retrolental fibroplasia–A disease of the retina in which a mass of scar tissue forms on back of the lens of the eye. Both eyes are affected in most cases and it occurs chiefly in infants born prematurely who receive excessive oxygen.

Rods and cones–See Cones and rods.

S. SC (Sine correction)–Without correction; that is, not wearing glasses.

Safety glasses–Impact resistant; available with or without visual correction for workshop or street wear protection, for both adults and children.

Sclera–The white part of the eye–a tough covering which, with the cornea, forms the external, protective coat of the eye.

Scleritis–Inflammation of the sclera.

Scotoma–A blind or partially blind area in the visual field.

Slit lamp–Provides a narrow beam of strong light; often used with a corneal microscope for examination of the front portions of the eye.

Snellen Chart–Used for testing central visual acuity. It consists of lines of letters, numbers or symbols in graded sizes drawn to Snellen measurements. Each size is labeled with the distance at which it can be read by the normal eye. Most often used for testing vision at distance of 20 feet.

Spherical lens–Segment of a sphere refracting rays of light equally in all meridians.

Stereoscopic vision–Ability to perceive relative position of objects in space without such cues as shadow, size, and overlapping.

Strabismus–Squint; failure of the two eyes simultaneously to direct their gaze at the same object because of muscle imbalance.

Strephosymbolia–A disorder of perception in which objects seem reversed as in a mirror. A reading difficulty inconsistent with a child's general intelligence beginning with confusion between similar but oppositely oriented letters, (b-d, q-p) and a tendency to reverse direction in reading.

Stye–Acute inflammation of a sebaceous gland in the margin of the eyelid, due to infection and usually resulting in the formation of pus.

Sympathetic ophthalmitis—Inflammation of one eye due to an infection in the other eye.

Synechia—Adhesion, usually of the iris to cornea or lens.

Tangent screen—A large black or gray curtain supported by a framework on which the normal central field and blind spot have been lightly outlined. This instrument is used for measuring the central field of vision.

Tarsus—The framework of connective tissue which gives shape to the eyelid.

Telescopic glasses— Magnifying spectacles founded on the principles of a telescope; occasionally prescribed for improving very poor vision which cannot be helped by ordinary glasses.

Tension, Intraocular—The pressure or tension of the contents of the eyeball.

Tonometer—An instrument for measuring pressure inside the eye.

Trachoma—A form of infectious kerato-conjunctivitis caused by a specific virus which in the chronic form produces severe scarring of the eyelids and cornea.

Tropia—A root word denoting an obvious deviation from normal of the axis of the eyes (strabismus) used with a prefix to denote the type of strabismus, as heterotropia, esotropia, exotropia.

Tunnel vision (Gun-Barrel, Tubular)—Contraction of the visual field to such an extent that only a small area of central visual acuity remains, thus giving the affected individual the impression of looking through a tunnel.

Uveal tract—Entire vascular coat of the eyeball. It consists of the iris, ciliary body, and choroid.

Uveitis—Inflammation of the uveal tract of the eye.

Vision—The art or faculty of seeing; sight.

Visual acuity—See Central visual acuity.

Visual purple—The pigment in the outer layers of the retina.

Vitreous—Transparent, colorless mass of soft, gelatinous material filling the eyeball behind the lens.

Vitreous opacities—See Floaters.

Self-Quiz #3

1. If a student is certified as deaf-blind, he/she is always totally deaf and totally blind.

   TRUE FALSE

2. A student is certified as blind if he/she has:

   a. Measured or estimated corrected vision of 20/100 or less
   b. A field of vision that is 20° or less in the better eye
   c. Cortically blind
   d. All of the above

3. The sensory mode used most frequently with deaf-blind students is that of ______________________________.

4. Give one example of tactually adapting the symbolic communication mode.

5. Skills taught to a deaf-blind student differ from those taught to a sighted and hearing student in what way?

Self-Quiz #4

1. Mental retardation is not a contributing factor to child abuse.

   TRUE FALSE

2. The ______________________________ mandates that teachers report suspected child abuse/neglect.

3. Once a teacher has reported his/her suspicions to the principal, his/her legal responsibilities end.

   TRUE FALSE

4. In Kansas the consequences of not reporting a suspected abuse/neglect case are:

5. Case workers try to maintain the child with his natural family except in severe cases of neglect/abuse where the child is at risk.

   TRUE FALSE

Mental Retardation Syndromes

and

Glossary of Medical Terms

Gwen Benson

INTRODUCTION

Many severely handicapped students exhibit characteristics which may result in their classification under some identifiable syndrome. Because there are medical, as well as educational implications related to various syndromes, educators should have some knowledge and awareness of the most common syndromes and information necessary in order to provide the best care and services possible.

An attempt has been made to select the most common syndromes and describe their level of retardation, etiology, characteristics, general health implications and medication and/or treatment. Asterisks (*) have been placed beside those syndromes which we feel teachers should be most familiar with; the remaining syndromes are presented for additional information and future reference.

By no means has the list of syndromes been exhausted. There are many syndromes which have not been included due to the rarity of reported cases and very little information is available regarding them.

Common across many of the syndromes is mental retardation and specific physical features. Cause and treatment are relatively vague for many syndromes and clear and precise for others. Also included in this section of the module is a glossary of medical terms related to the syndromes in this module. Both the syndrome section and the glossary should be very useful references to have when interacting with medical staff, reading medical records and, of course, to more effectively work with students.

Syndromes Covered

1. Albright's Hereditary Osteodystrophy
2. Apert's Syndrome
3. Ataxia Telangiectasia
4. Cornelia de Lange's Syndrome*
5. Cri du Chat Syndrome*
6. Crouzon's Disease
7. Cytomegalia Inclusion Disease
8. Down's Syndrome*
9. Fetal Alcohol Syndrome*
10. Homocystinuria
11. Hunter's Syndrome*
12. Hurler's Syndrome*
13. Hydrocephalus*
14. Hyperuricemia*
15. Hypothyroidism
16. Kernicterus
17. Klinefelter's*
18. Maple Syrup Urine Disease
19. Microcephaly*
20. Neurofibromotosis
21. Osteogenesis
22. Phenylketonuria*
23. Rubella*
24. Sturge-Weber Syndrome
25. Tay-Sachs Disease*
26. Trisomy D
27. Trisomy E
28. Tuberous Sclerosis*
29. Turner's Syndrome *
30. Wilson's Disease

*Syndromes which the classroom teacher should be most familiar with.

SYNDROME	Level of Mental Retar.	Etiology	Characteristics	GENERAL HEALTH IMPLICATIONS	MEDICATIONS &/or TREATMENT
Albright's Hereditary Osteodystrophy	Varies from normal intelligence to severe retardation.	Transmitted by an autosomal dominant trait with highly variable expressivity (i.e. the ability of a gene to manifest it's effect in the organism).	Physical: 1) short stature w/stocky build. 2) cataracts 3) blue sclerae (the hard white outer membrane of the eye) 4) strabismus 5) possible skeletal abnormalities of the hand and feet	Prone to seizures	Vitamin D might be useful to prevent skeletal deformities. Surgical corrections may be needed for the eyes & skeletal abnormalities. Anti-convulsive medication.
Apert's Syndrome	Varying degrees of severity.	Autosomal dominant trait.	Physical: 1) Syndactyly (webbing) of the hands and feet 2) Craneostenosis (i.e. the bones of the skull close prematurely resulting in cranial abnormalities) 3) Hypertelorism (i.e. eyes set far apart 4) Broad face and short broad nose 5) Triangular shaped mouth and a very high arched narrow palate	Progressive hearing loss may result from displaced auditory nerve.	Surgical correction of the syndatyly. Surgery during the 1st few months of life has been done in some cases to prevent the craneostenosis.
Ataxia Telangiectasia (Louis-Bar Syndrome)	MR occurs in about 1/3 of the cases.	Hereditary disorder with an autosomal recessive type.	Physical: 1) Dilation of blood capillaries (Telanjectasia) in the face, ears, neck, hands, wrists, knees and front of the elbows 2) Ataxia	Frequent respiratory infections and an abnormal immune mechanism.	Antibiotics for infection and postural drainage for respiratory.

SYNDROME	Level of Mental Retar.	Etiology	Characteristics	GENERAL HEALTH IMPLICATIONS	MEDICATIONS &/or TREATMENT
Cornelia de Lange's Syndrome*	Severe	Unknown; however, chromosomal abnormalities have been found in some cases.	Physical: 1) Abnormal growth of hair, especially the eyebrows and eyelashes and on the forehead, upper lip, center of the back and the forearms. 2) Below the third percentile in height and weight. 3) Nasal bridge is often depressed and the nostrils turned forward. 4) Syndactyly (webbing) of the fingers and the 2nd and 3rd toes. 5) Congential hip deterioration 6) Underdevelopment of the nipples and male genitalia; delayed menstruation and infertility. 7) Delayed bone maturation. Behavioral: 1) Hyperactive and restless 2) Self-mutilating and destructive 3) Teeth-grinding is common	Frequent respiratory infections	Prosthesis for malformed limbs. Care should be taken during feeding to prevent aspiration. Infections shoul be treated promptly.
Cri du Chat Syndrome* (Cat Cry)	Severe	Autosomal abnormality	Physical: 1) Infant's cry sounds like mewing of a cat. This is caused by abnormal vocal chords and upper larynx. 2) Microcephalic 3) Failure to thrive 4) Rounded face and low set ears 5) Hypertelorism (eyes set far apart) 6) Strabismus	Various types of congenital heart defects may be present	No known treatment
Crouzon's Disease	Usually not present unless there is brain damage due increased intracranial pressure.	Autosomal dominant type of inheritance in 25% - 50% of the cases.	Physical: 1) Exophthalmos (i.e. protruding eyeballs), strabismus, nystagmus, hypertelorism (eyes set far apart) 2) Abnormally shaped head 3) Beached nose	Occasional deafness; hernias, spina-bifida and dwarfism	Early surgical intervention is required if ther is increasing intracranial pressure or progressive exophthalmus

SYNDROME	Level of Mental Retar.	Etiology	Characteristics	GENERAL HEALTH IMPLICATIONS	MEDICATIONS &/or TREATMENT
Cytomegalia Inclusion Disease	Varies from minimal to severe	Not inherited	Physical: 1) Failure to thrive 2) Microcephaly 3) Chorioretinitis (inflamation of the chorord coat of the eye & retina) 4) Optic atrophy (degeneration of the major nerve in the posterior part of the eyeball) 5) Nystagmus and strabismus 6) Purgura (small round purple-red spots over any part of the body) 7) Jaundice 8) Diplegia with spasticity	Seizures; pneumonites, respiratory distress and congestive failure. Anemia	Anticonvulsants for seizures. Anemia should be treated.
Down's Syndrome*	Usually moderate, but may range considerably.	Autosomal aberration of chromosome number (i.e. 47 chromosomes instead of 46). Associated with later maternal age.	Physical: 1) Hypotonia (present at birth but generally improves with time) 2) Small head which is flat in front and back 3) Eye cavities are small 4) Short broad neck with lax skin at the sides of the neck 5) Eyes are small almond shaped, slanted up toward sides of head 6) An epicanthus (skin fold) curves up around the nasal side of the eyes 7) Nose is small and short; short bridge due to underdeveloped nasal bones 8) Small mouth with thick tongue 9) Teeth are late in erupting and usually small and poorly aligned 10) Extremities are short, especially the fingers and toes 11) Spaces between the 1st and 2nd fingers and toes are abnormally wide 12) Genitals are poorly developed 13) Skin is coarse and dry 14) Simian palmar crease	Susceptible to respiratory infections Ca Cardiac problems	Antibiotics for respiratory infections

SYNDROME	Level of Mental Retar.	Etiology	Characteristics	GENERAL HEALTH IMPLICATIONS	MEDICATIONS &/or TREATMENT
Hyperuricemia (Cont.)			Behavioral: 1) Normal appearing at birth but by 2 months begins showing irratability. 2) Frequent vomiting between 6 months and one year of age. 3) Self mutilation by 2 years of age manifested by lip biting, finger-chewing, teethgrinding and marked swinging of the arms. 4) Aggressive towards others with use of foul language, striking and biting. 5) Do not feel pain and will plead with an observer to keep them from biting or mutilating themselves.		
Hypothyroidism Congenital (Cretinism)	Varies in severity according to degree of thyroid insufficiency	Not hereditary. May be caused by inadequate maternal intake of iodine during pregnancy.	Physical: 1) Delayed skeletal maturation. 2) Thick protruding tongue 3) Coarse, brittle, and scanty hair 4) Hairline begins far down on forehead 5) Short extremities 6) Broad hands with short fingers 7) Motor retardation 8) Dry skin 9) Hypotonic Behavioral: Eats poorly	Respiratory difficulties secondary to the large tongue. Prone to constipation.	Administration of thyroxin or other synthetic thyroid hormone.
Kernicterus	Minimal to severe* *treatment can prevent	Not hereditary. May occur secondary to blood incompatibility such as RH factor, sepsis (blood poisoning), or enzyme abnormalities in liver.	Physical: 1) Nystagmus 2) Nerve/high tone deafness 3) Jaundice Behavioral: 1) Eats poorly	Seizures Muscular rigidity Vomiting during acute stage	Anti-convulsant medication. Complete blood transfusion at birth can prevent Kernicterus. Physical therapy to alleviate mus-

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SYNDROME	Level of Mental Retar.	Etiology	Characteristics	GENERAL HEALTH IMPLICATIONS	MEDICATIONS &/or TREATMENT
Klinefelters*	Moderate retardation in a quarter of the reported cases.	Genetic abnormality (excessive X-linked chromosome patterns) found only in males. Occurs approximately every 1 in 400 live male births.	Physical: 1) Small testes, can be non-functional for sperm production. 2) Development of breasts. 3) Sparse pubic hair. 4) Scoliosis and other skeletal deformities.	Prone to leukemia. Prone to asthma and other pulmonary diseases.	Hormonal treatment to promote secondary sexual characteristics.
Maple Syrup Urine Disease (Branched-chain Amino Aciduria) (Leucinosis)	Severe	Hereditary; caused by an autosomal recessive gene. Found in all races.	Physical:* 1) Ataxia (failure of muscle coordination) 2) Maple syrup odor in urine *characteristics will develop within 3-7 days after birth.	Body is unable to metabolize certain amino acids. If not treated, it will result in death. Failure to thrive. Vomiting Progressive	Diet omitting the causal 3 amino acids
Microcephaly*	Moderate to profound	Hereditary; Caused by autosomal recessive gene.	Physical: 1) Small head with sloping forehead. 2) Scalp is furrowed. 3) Hypertonia 4) Retarded motor development		No specific treatments
Neurofibromotosis (von Recklinghausen Disease)	Varies, secondary to tumor development in the brain	Congenital. Believed to be transmitted by autosomal dominant mode, although there have been some exceptions. Occurs approx. 1 in 2000 births.	Physical: * 1) Tumors in the brain 2) Tumors in spinal cord 3) Skin tumors *Can appear between the ages of 1-5.	Visual problems related to tumor growth in eyes Bowel obstruction caused by tumors Dizziness Hearing loss	Surgical removal of tumors

SYNDROME	Level of Mental Retar.	Etiology	Characteristics	GENERAL HEALTH IMPLICATIONS	MEDICATIONS &/or TREATMENT
*Turner's Syndrome	Mild: low incidence	Abnormality of sex chromosome number due to nondisjunction during formation of the ovum or sperm (failure of chromosome to separate and go to different cells when the cell divides). There are 45 chromosomes instead of 46.	Physical: 1) Short and/or webbed neck 2) Breasts and external genitals do not develop 3) Wide chest with broadly spaced nipples 4) Protruding and/or low set ears 5) Low back hairline 6) Folds in eyelid skin 7) Backs of hands and upper surfaces of feet often swollen with fluid 8) Multiple pigmented raised spots on the skin 9) Skeletal defects 10) Deafness	Congenital heart disease Kidney abnormalities	Hormonal therapy used at the proper time can increase secondary sexual maturation (i.e. estrogen replacement therapy).
Wilson's Disease (Ceruloplasmin Deficiency)	Varies	Inherited by an autosomal recessive gene caused by deficiency in the blood plasma (protein cerulo plasmin)	Physical: 1) Set facial expression with open, drooling mouth and teeth exposed in a grimacing smile 2) Green, ring-like lesion surrounding the outer edge in the cornea of the eye (Kayser-Fleisher Ring) 3) Involuntary movements such as tremors 4) Difficulty in swallowing 5) Excessive thinness 6) Enlarged liver 7) Speech disturbances	Occasional seizures Deteriorating liver structure Brain stem degenerates	Dietary regimen that lowers the copper balance within the body. Drug therapy treatement which is effective in increasing the output of copper in the urine. Anticonvulsant medication for seizure control.

Glossary of Terms

Achondroplasia:	A condition of abnormal bone development resulting in dwarfism.
Acrocephaly:	A condition in which the top of the head is pointed.
Aggression:	Hostile, malevolent, or unfriendly behavior.
Anemia:	A decrease in the number of red blood cells or hemoglobin concentration resulting in a deficiency in the oxygen-carrying capactiy of the blood.
Anomaly, crania:	Abnormal structure of the cranium.
Anoxemia:	Reduction in oxygen content of the blood to a level insufficient to maintain adequate functioning of tissue.
Anticonvulsant:	An agent which acts to prevent seizures. Most frequently used are Phenobarbitol, Dilantin, Mysoline, Xarontin.
Aplasia:	Absence, defective development, or atrophy of a tissue, organ, or part of the body.
Apraxia:	Inability to perform purposeful movement in absence of muscular paralysis or sensory disturbance.
Astigmatism:	Defective curvature of the refractive surface of the eye as a result of which a ray of light is not sharply focused on the retina but is spread over a more or less diffused area.
Ataxia:	Lack of normal muscular coordination. This usually refers to incoordination associated with abnormalities of the cerebellum of afferent proprioceptive sensation. Balance and kinesthesis are disturbed.

Athetosis:	A condition of involuntary, slow, writhing movements principally of hands and feet, due to a brain lesion.
Atonia:	Lack of muscle tone.
Atrophy, cerebral cortical:	An acquired reduction in the size of the cerebral cortex.
Autosomal Recessive Trait:	A trait resulting from the combination of two recessive genes.
Ballismus:	A form of motor dysfunction characterized by jerking, twitching, and swinging movements of limbs.
Bilirubin:	The reddish-orange pigment of bile.
Brushfield Spots:	Small, whitish-yellow dots at the periphery of the iris. Seen in Down's Syndrome children and also in some normal children.
Cardiac:	Pertaining to the heart.
Cerebral Palsy:	A group of nonprogressive disorders resulting from malfunction of the motor centers and pathways of the brain. Characterized by paralysis, weakness, incoordination, or other abnormalities of motor function which have their origin prenatally, during birth or before the CNS has reached relative maturity. Other deficits (sensory, mental retardation) are frequently associated with the motor deficits.
Chorea:	A motor dysfunction characterized by involuntary, jerking movements of extremities and facial muscles.
Chromosome:	The bodies in the cell nucleus which carry the genes (heriditary factors).

Congenital:	Present at birth.
Contracture:	A shortening of the muscle tendon that results in a limited range of motion in a joint.
Convulsion:	A violent, involuntary series of muscular contractions
Craniosynostosis:	Premature closure of the sutures of the skull causing deformation of the head and possibly damage to the brain.
Cretinism:	A type of mental deficiency resulting from a deficiency in thyroid secretion.
Cyanosis:	A bluish skin color, resulting from insufficient oxygenation of the blood.
Deafness:	Hearing impaired to the degree that it is of little or no utility for the purposes of ordinary communication.
Degeneration:	A progressive deterioration.
Desquamate:	To shed or peel, as of the skin. Desquamated skin is flaky and scaly.
Diplegia, cerebral:	Paralysis or motor dysfunction of like parts on both sides of the body.
Dystonia:	Disorder of muscle tone.
Extopia:	Abnormal position of an organ or body part.
Encephalo-myelopathy:	Any disease or condition affecting the brain and spinal cord.
Encephalopathy:	Any disease or condition affecting the brain
Endocrine:	Pertaining to those glands whose secretions pass directly into the blood stream such as the pituitary and thyroid.

Epicanthus:	An anomaly in which the inner junction of the eyelids is covered by a fold of skin.
Epilepsy:	A cerebral disorder manifested by transient disturbances in motor and/or sensory function.
Etiology:	The cause of a disease or condition.
Fibrile Seizure: (convulsions)	Seizures in infants or young children whose onset is precipated by a high fever in conjunction with a non-CNS infection. These seizures usually disappear when the central nervous system has matured (about 5 years of age).
Gene:	Any of those parts of the chromosome which transmit hereditary characteristics.
Gene (dormant):	A gene which produces its effect regardless of whether it is matched by a like gene in the other chromosome of the pair concerned.
Gene (multiple):	A gene whose individual effects are small and combine with other multiple genes to produce an additive effect.
Gene (recessive):	A gene which produces its effect only when matched by a like gene in the other chromosome of the pair concerned.
Hemiplegia:	Paralysis of one lateral half of the body.
Hepatosplenomegaly:	Increase in size of liver and spleen.
Hyperkenetic:	Excessive movement.
Hydrocephalus:	An excess of cerebrospinal fluid in the ventricular and subarachnoid spaces of the brain.
Jaundice:	A condition characterized by yellowish skin and mucus membranes due to bilirubin in the blood stream.

Jacksonian epilepsy:	A form of epilepsy in which the seizure is limited to one leg or to one part of the body, usually without the loss of consciousness.
Macrogyria:	A congenital defect characterized by unusually large cerebral convolutions.
Microcephaly:	The failure of normal brain growth resulting in a small head size (microcrania).
Micromelia:	Abnormally small limbs.
Motor:	Pertaining to movement.
Myopia:	Nearsightedness.
Myxedema:	A disorder characterized by lethargy and dullness resulting from a lack of thyroid secretion.
Nodules:	Small knobs or protuberances resulting from skin lesions.
Nystagmus:	An involuntary, rapid, jerking movement of the eyeball. May be either lateral, vertical, rotary, or mixed.
Organic:	Pertaining to the structure of organs.
Ossification:	Formation of bone; state or process of being converted into bone.
Papilledema:	Swelling of the optic nerve.
Paralysis:	Loss or impairment of motor function.
Paraplegia:	Paralysis of the legs and lower part of the body.

Petit Mal Seizure:	A transient loss of consciousness with perhaps a slight movement of head, eyes, lips, limbs or trunk.
Phenylalanine:	An amino acid essential in human nutrition.
Prematurity:	Refers to the condition,in which infants are born before the full gestation period or weigh less than 5½ lbs. at birth.
Quadriplegia:	Motor dysfunction of equal severity in all four extremities.
Recessive:	A trait which is expressed in individuals who are homozygous for a particular gene but not in those who are heterozygous for this gene.
Rigidity:	Refers to muscular immobility. Also used as a psychological term to refer to inflexibility or lack of adaptability of behavior.
Seizure:	An epileptic attack.
Scoliosis:	Lateral curvature of the spine.
Simian Crease:	A single transverse palmar crease instead of the creases normally seen on the palm.
Spasticity:	Increased muscular tension associated with exaggeration of deep reflexes, involuntary muscle contractions, and partial loss of voluntary movement.
Status epilepticus:	A condition in which a number of seizures follow in rapid succession during which time the patient is unconscious.
Strabismus:	Squint, a visual defect due to inability to direct the eyes to the same point as a result of incoordination of ocular muscles.

Syndrome:	A group of symptoms which, in combination, characterize a disease or condition.
Therapy:	Treatment or remediation.
Tic:	A spasmodic moving or twitching of a group of muscles which on the surface bears no relation to the individual's problems.
Toxemia:	A condition in which the blood contains toxic or poisonous substances.
Trisomy:	A chromosome additional to the normal complement (i.e. 2n + 1) so that in each nucleus one particular chromosome is represented three times rather than twice.
X-linkage:	Genes carried on the x chromosome are said to be x-linked.

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Self-quiz # 5

1. Which of the following syndromes is a result of an autosomal anomaly.

    a. Down's Syndrome
    b. Cri du Chat Syndrome
    c. Fetal Alcohol Syndrome
    d. a & b

2. Decreasing the level of uric acid is a treatment for ________________.

3. A treatment for hydrocephalus is ______________________.

4. Physical therapy is used to avoid contractures in which of the following:

    a. Down's Syndrome
    b. Hunter's Syndrome
    c. Hurler's Syndrome
    d. b & c

5. Which of the following syndromes has progressive nerve deafness as a major characteristic?

    a. Cri du Chat
    b. Hunter's
    c. Down's
    d. Hurler's

6. Down's Syndrome children are susceptible to respiratory infection.

    True   False

7. Providing prosthesis for malformed limbs is a treatment for:

    a. Cri du Chat Syndrome
    b. Hyperuricemia
    c. Cornelia de Lange Syndrome
    d. Down's Syndrome

8. Hormonal therapy to promote increased secondary sexual characteristics is used in treating ______________________ syndrome, and ____________ ______________ syndrome.

9. The most obvious characteristic of Lesch-Nyhan Syndrome is ____________ ________________ behavior.

10. Which of the following is characteristic of microcephaly:

    a. abnormally small head
    b. abnormally small limbs
    c. enlarged head
    d. enlarged limbs

Self-quiz #5 (Cont.)

11. A low phenylalinine diet has found to be a very effective treatment of:

    a. Tay-Sachs
    b. microcephaly
    c. Phenylketonuria (PKU)
    d. Down's

12. Tay-Sachs Disease:

    a. causes progressive degeneration of the central nervous system.
    b. is an inherited genetic disorder.
    c. has no known treatment.
    d. all of the above

13. Which of the following is a chromosomal aberration?

    a. Trisomy D
    b. Down's
    c. Lesch-Nyhan
    d. a & b

14. Numerous tumor-like masses are characteristic of ________ ________.

Self-quiz # 6

1. Match the terms in the left column with the correct definition in the right column.

a. Petit Mal
b. Status epilepticus
c. congenital
d. achondroplasia
e. trisomy
f. hydrocephalus
g. simian crease
h. etiology

____ Present at birth

____ a single transverse line found on the palm

____ a transient loss of consciousness with perhaps a slight movement of head, eyes, lips, limbs or trunk

____ an excess of cerebrospinal fluid in the brain

____ seizures which follow in rapid succession

____ the cause of a disease or condition

____ a chromosomal anomaly in which a chromosome is represented 3 times rather than twice

2. Match the terms in the left column with the correct definition in the right column.

a. encephalopathy
b. nystagmus
c. paraplegia
d. athetosis
e. hyperkinetic
f. cyanosis
g. ataxia
h. hirsutism

____ involuntary, slow, writhing movements principally of hands and feet

____ any disease or condition affecting the brain

____ balance and kinesthesis are disturbed

____ involuntary, rapid, jerking movement of the eyeball

____ paralysis of the legs and lower part of the body

____ bluish skin color resulting from insufficient oxygenation of the blood

____ excessive movement

Answers to Self-Quizzes

①

1. Any 4 of the following:
   1) The use of individual materials in teaching self-help skills.
   2) Thoroughly cleaning dishes, utensils, glasses, or bibs used in feeding programs each time they are sued.
   3) Washing hands frequently.
   4) Daily cleaning and disinfecting of commodes, diaper table and diaper pail.
   5) Proper storage of used washcloths, towels, and wet clothes.
   6) Immediate rinsing and disposing of diapers.

2. 1. Checking and cleaning of adaptive equipment.
   2. Washing of toys and program materials.
   3. Clea of furniture (chairs, desktops, tables, etc.).
   4. Keeping floor area clean.
   5. Proper storage of food used in tne classroom.

3. 1) to control contagion of illnesses
   2) to be alerted for signs of possible student health problems

4. False

5. e

6. 1) Identification of any chronic illness or health problem which a student has.
   2) Staff training in specific emergency care.
   3) Formulation of specific plan of action, with emergency information being noted in an easily accessible place.

7. b

8. fatigue
   sore muscles
   nausea or headache
   behavioral changes such as irritability, restlessness, aggression

9. Petit mal seizures

10. seizures
    allergies
    asthma
    choking
    foreign objects in eye, ears or nose
    sunburn
    bleeding
    poor circulation
    swallowing of objects
    ingestion of poisenous substance
    shock

②

1. c

2. specific and precise

3. The teacher must determine whether the evaluation instrument is appropriate. Many consultants have very little experience in working with severely handicapped students. Their evaluation instruments may have been designed for a higher functioning population.

4. The physician should be interested in the teacher's follow-up reports as a method to help determine whether or not his treatment was successful. An example could be any of the following:

   a) Monitoring seizures to see if prescribed medication is controlling them.
   b) Monitoring the number of urinations and the color of the urine to help determine whether medication has cleared up a kidney infection.
   c) Monitoring fluid intake during antibiotic treatments.

5. True

③

1. False

2. d

3. Touch (tactile)

4. Any of the following: braille, raised letters, use of different textures

5. No difference in the skills themselves as long as the skills are those appropriate for the individual needs of the student.

④

1. False

2. Kansas Child Protection Act

3. False

4. $1000
   6 months in jail
   both
   liability for legal suits

5. True

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⑤

1. d
2. hyperuricemia
3. shunting
4. d
5. b
6. True
7. c
8. Klinefelter's and Turner's
9. self-mutilating
10. a
11. c
12. d
13. d
14. tuberous sclerosis

⑥

1.	2.
c	d
g	a
a	g
f	b
b	c
h	f
e	e

Appendix B

(Outline of Procedures Manual)

Procedures Manual

I

GENERAL INTRODUCTION AND BACKGROUND

What is inservice training?

Purpose and intent of our project.

Need for inservice training.

Premises of the project.

PROJECT ORGANIZATION AND COORDINATION WITH OTHER AGENCIES

Organization and Structure at the University of Kansas

Coordination with the Kansas State Department of Special Education

RECRUITMENT AND ENROLLMENT

Trainee Identification

Apportionment of the State

Trainee Enrollment in the SMH Program

Replication of the Model

DESCRIPTION OF THE CURRICULUM

Content Development of the Program

- Invited Consultants.
- Teachers and Administrators.
- Published Resources.

Competency Organization

Instructional Formats

- Modular.
- Lecture.
- Field-based Practica.
- Workshops.

II
DESIGNING INSTRUCTIONAL MODULES

Introduction-Why the modular format is used.

Considerations

Modular Organization

Evaluation/Revisions

Problems with Modular Format

Developing an Instructional Module

III
CONSIDERATIONS FOR DESIGNING INSERVICE PRACTICUM TRAINING EXPERIENCES

Realism.

Range.

Sequential Organization.

The Statewide Inservice Practicum Model

Performance Objectives

Organization of Practica

Basic Practicum.

Intermediate Practicum.

Advanced Practicum.

Setting

Travel.

Student Characteristics.

Existing Classroom Model.

Practicum Supervisors

Staff Organization.

Staff Preparation and Criteria.

Competency Evaluation

Model.

Instruments.

Problems.

Revisions

Appendix C

(Observation and Management Forms)

TPC I

TEACHING IMPLEMENTATION
OBSERVATION FORM
Adapted from The Early On Program

Student(s): ________ ____ ____________ ____________

Teacher ____________

Observer ____________

Date & Time ____________

Activities:

RECORDING PROCEDURES: *Observe teacher for 10-15 trials and record an X if behavior observed does not meet criteria listed on next page. Put NA or a line through nonapplicable sections. 80-100% is acceptable.*

Prior to conducting session trainer :

1. Has all required materials	Yes	No--List missing items
2. Has complete programs and STEP in classroom	Yes	Yes, but________, No
3. Seating arrangement appropriate	Yes	No--Tell why
4. Ss Adaptive equipment working/on	Yes	No (not avail) No (forgot) NA
5. Uses recommended reinforcer	Yes	No

During session, trainer

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
6. Attends to student behav.															
7. Materials															
A. Discriminable															
B. Positioned optimally															
C. Out of student's reach															
D. Within implementer's reach															
8. Cues (S^D's)															
A. Clear															
B. Correct wording															
C. Not repeated															
D. S positioned optimally															
9. Reinforcement: Indiv.															
A. For correct behavior															
B. Immediate															
C. Paired															
D. Schedule correct															
E. Appropriate intensity															
10. Reinforcement: Group															
11. Handles Inappropriates															
A. Interrupts incompatibles															
B. Implements correctly															
C. Correct schedule															
D. Immediate															
12. Correction Procedures															
A. Correct															
B. Immediate															
13. Data Recorded															

Score after training session:

14. Pacing appropriate	Yes	No--state slow component
15. Trials alternated (within student)	Yes	No
16. Trials alternated (between students)	Yes	Yes, but________, No, NA
17. DRO provided if deceleration used	Yes	No NA
18. Independent activities provided	Yes,	Yes, but________, No, NA
19. Interruptions handled	Yes	No NA
20. Summarizes data	Yes	No
21. Plots data	Yes	No

HOW TO FILL OUT THE TPC I

Prior to Conducting Session:

1. Teacher has all materials necessary for the program at hand before program begins.

2. Teacher has formally written programs and corresponding STEP File cards, in the classroom.

3. Students and teacher are seated in such a way that eye contact can be obtained, materials can be reached, chairs are appropriate height, support and teacher can touch each student.

4. All students who use adaptive equipment must be wearing it; all equipment should be functioning.

5. Either preferred reinforcer from Reinforcer Survey is used or a reinforcer that has been shown to be effective in other programs.

During Session:

6. Attention is obtained prior to the begining of each trial.

7. A. Materials can be clearly seen/heard/felt by child (non-instruction supplies out of sight.
   B. Materials positioned considering the student's handicap (e.g. range of motion).
   C. Materials are out of reach/sight of child between trials (unless program states otherwise).
   D. Implementor can easily reach materials

8. A. Signals/commands can easily be seen/heard/felt by the child.
   B. Signals/commands correspond to ones specified in written program.
   C. The initial signal/command is given one time unless otherwise indicated in written program. Any following signals/commands must be part of the correction procedure.
   D. Student is positioned to see/hear/feel signals/commands considering his/her handicaps.

9. A. Reinforcement is given for the behavior as defined by the program.
   B. Reinforcers are presented immediately after correct response.
   C. Reinforcement is always paired with social
   D. Reinforcement is administered using schedule specified in written program.
   E. Intensity or strength of reinforcement corresponds to performance of student.

10. Intermittent reinforcement is provided to students in group while engaged in independent activities.

11. A. Teacher interrupts any behavior that is incompatible with target response.
    B. If there is an ongoing deceleration program for the exhibited inappropriate behavior, this should be implemented as written.
    C. If there is an ongoing deceleration program for the exhibited inappropriate behavior, the schedule should be followed.
    D. Incompatible behavior is consequated immediately.

12. A. Correction procedure used corresponds to one specified in written program.
    B. Correction is presented immediately following the incorrect response.

13. Teacher records data following a reasonable number of responses.

Score After Training Session:

14. Pacing of activity reflects immediate reinforcing, correcting and data-recording in a non-interfering manner, and signals for next trial given soon after data-recording.

15. Trials of the student's sequence should be alternated as stated on the data sheet (or elsewhere).

16. Sequences are alternated among students in the group.

17. Reinforcement should be given for appropriate (and incompatible) behaviors if the student is in a deceleration program. These can be scheduled in the sequence.

18. Between trials implementor arranges for each student to be engaged in an activity which is incompatible with stereotypic or disrupting behaviors.

19. Teacher handles unexpected interruptions (e.g. visitors in classroom) so that the least amount of interference occurs in the ongoing programming.

20. Teacher summarizes the data to be in a form for graphing.

21. Teacher plots data on all required graphs (as indicated in written program).

Group Observation Form
(Adapted from the Early On Program)

Students/ # of behaviors per sequence ______________/______
______________/______
______________/______
______________/______
______________/______

Theme: ______________
Teacher: ______________
Observer: ______________
Date: ______________
Time: ______________

Prior to Conducting Session Trainer:

1. Has all required materials yes no
2. Has all programs in classroom yes no
3. Data sheet
   a. indicates each Student's name yes no
   b. indicates each student's step yes no
   c. indicates each student's correction code yes no

During Training (each trial reflects entire sequence)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
5. Materials															
a. discriminable															
b. positioned optimally															
c. out of other students reach															
6. Cues															
a. clear															
b. correct wording															
c. not repeated															
d. S's positioned optimally															
7. Reinforcement: Individual															
a. at correct time in sequence															
b. immediate															
c. paired															
d. schedule correct															
e. appropriate intensity															
8. Follows sequence															
9. Corrects each behavior w/in sequence															
10. Handles inappropriates															
a. interrupts priority beh. probl.															
b. returns to sequence															
c. completes beh. prog. when applic.															
d. prevents occassion for following behavior problems															

Group Observation Form
Page 2

Score After Training:

11.	Sequencing			
	a. correction procedure appropriate length	yes	no	
	b. sequence appropriate length	yes	no	
	c. trials alternated between student	yes	no	
	d. trials alternatied within student	yes	no	
	e. pacing appropriate	yes	no	
	f. takes data at realistic intervals	yes	no	
12.	Seating arrangement			
	a. next to complimentary student	yes	no	
	b. close enough to students to have contact	yes	no	
13.	Content			
	a. common theme	yes	no	na
	b. intermittent "programmed" interaction between S's or behaviors (S's as antecedents)	yes	no	na
	c. behavior checks	yes	no	na
14.	Use of aides (if applicable)			
	a. aides have structured responsibility	yes	no	

General Classroom Observation

(For all students in the class)

Written Programs: Total number of programs ______ Number missing _____

A. Some format for all ongoing programs

	# missing
1. Title	
2. Rationale	
3. Behavioral objective	
4. Definition of response	
5. Materials	
6. Cue	
7. Correction Procedure	
8. Data recording	

Graphing: Total number of graphs _______ Number missing _____

A. Uses correct format

	# missing
1. Ordinate labeled	
2. Abscissa dated	
3. Criterion line	
4. Ceiling line	
5. Phase change lines	

B. Data Decisions

1. Baseline changed to training at appropriate point.	
2. Procedures changed on or before 10 days of non-criterion performance.	
3. Activity changed after specified number of criterion days.	

Scheduling

A. Posted Classroom Schedule (showing teacher's assistants and students activities). Yes No

B. Related to ongoing activity (observe 3 times) ☐ ☐ ☐

C. Individual schedule for each student in class (specify program title)

1. Coincides with class schedule. How many? Yes ☐ No ☐
2. No student with more than 1 hour of down time in 6 hour day. How many? Yes ☐ No ☐
3. Each student in at least 2 (small) groups. How many? Yes ☐ No ☐

Statewide Inservice Training Project
for Teachers of the Severely/Multiply Handicapped
Department of Special Education, The University of Kansas

ASSESSMENT ADMINISTRATION PROFICIENCY CHECKLIST

Student Teacher ______________________________

Pracitucm Supervisor ______________________________

Student Name ______________________________

Assessment Used ______________________________

PREPARATION

5 pts. 1. Assessment appropriate — Yes No

5 pts. 2. Use/non-use of reinforcement for correct, incorrect, approximations and no responses is pre-determined. — Yes No

5 pts. 3. All needed materials/equipment in area. — Yes No

20 TRIAL SAMPLE

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
10 pts. 4. Cue clear.																				
10 pts. 5. Reinforcement correct.																				
10 pts. 6. Trial recorded.																				

	11	12	13	14	15	16	17	18	19	20
10 pts. 7. Reliability										

POST ASSESSMENT

10 pts. 8. Assessment totaled/profiled in meaningful way. — Yes No

15 pts. 9. At least 2 skill deficits from all curriculum areas are identified. — Yes No

5 pts. 10. Adds assessment score to records. — Yes No

SCORE: ______ / 85 x 100 = ______ %

90-100% = A
80-89 % = B
70-79 % = C
60-69 % = D
Less than 59 % = F

GRAPH DESIGN CHECKLIST

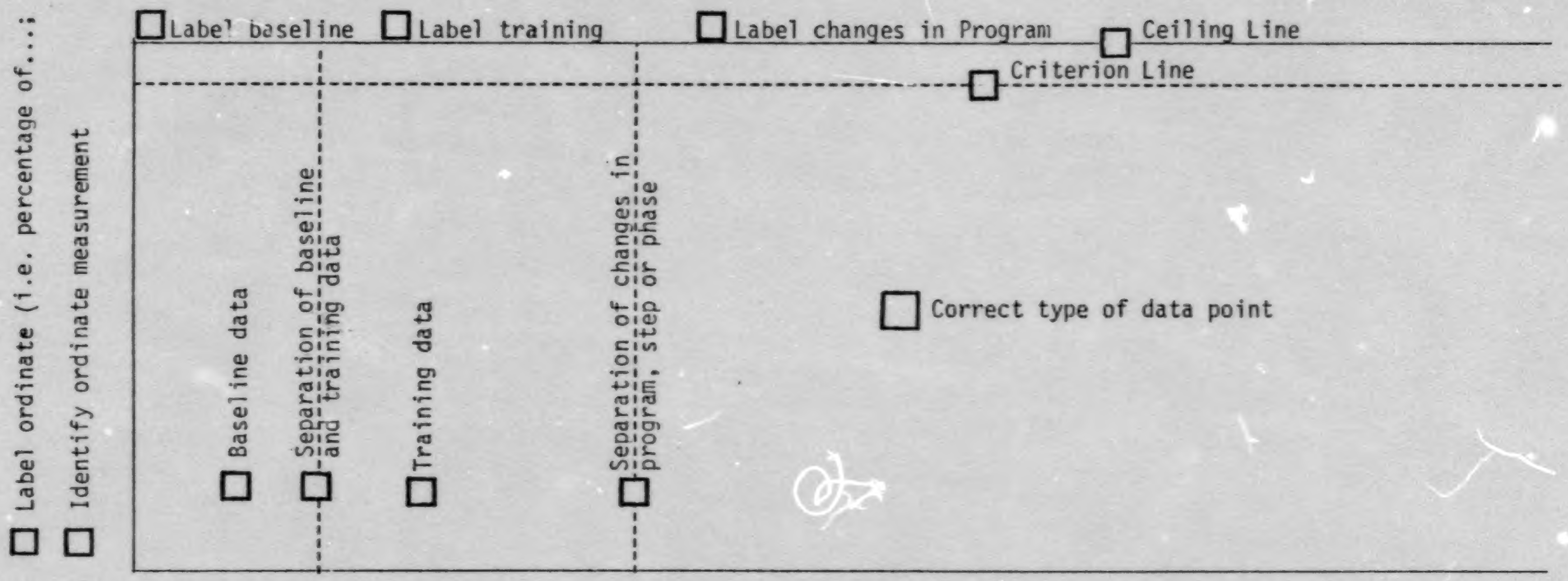
☐ Name of Program ____________________

☐ Skill(s) taught ____________________

☐ Student's Name ____________________

☐ Trainer's Name ____________________

☐ Reinforcer ____________________



☐ Label baseline

☐ Label training

☐ Label changes in Program

☐ Ceiling Line

☐ Criterion Line

☐ Label ordinate (i.e. percentage of...; correct number of...)

☐ Identify ordinate measurement

☐ Baseline data

☐ Separation of baseline and training data

☐ Training data

☐ Separation of changes in program, step or phase

☐ Correct type of data point

☐ Identify abscissa measurement

☐ Label abscissa

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REINFORCER SURVEY CHECKLIST

Teacher: ______________________ Date: ____________

Supervisor: ____________________

Environmental Factors

1. Is area prepared for survey? Yes No
2. Is the positioning appropriate for the student? Yes No
3. Are precautions made for the possible occurance of inappropriate behavior? (i.e. shield, items on tray, etc.) Yes No
4. Are the items chosen age-appropriate for the student? Yes No
5. Was a trial taste of each item given prior to administration of the survey? Yes No

Administration

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Point to each item															
2. Clear Cue															
3. Data Recorded															
4. Position Noted															
5. Rearrange Items															

Evaluation

1. Did the teacher tally the score? Yes No
2. Checklist Score __________
3. Reliability Score __________

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STEP Check

	Student 1	2	3	4
I. Cover Information--10 pts (1 ea.)				
1. Student's full name				
2. Birthdate				
3. Parent's name				
4. Parent's address				
5. Parent's phone number				
6. Student's residence				
7. Emergency contact and phone #				
8. Dr.'s name and phone #				
9. Preferred hospital				
10. Current educational placement				
II. Precautionary Information (9 pts)				
A. Health				
1. Allergies (1 pt)				
2. Immunizations (1 pt)				
3. Handicaps (1 pt)				
B. Medications				
1. Name (1 pt)				
2. Amount (1 pt)				
3. Start date (pt)				
4. Stop date (1 pt) S should indicate if no stop date				
C. Danger				
1. Behavior problems (1 pt)				
2. Orthopedic precautions (1 pt)				
III. Orthopedic--(6 pts)				
A. Positioning				
1. Beneficial positions (1 pt)				
2. Transfers (1 pt)				
3. Carries (1 pt)				
B. Adaptive Equipment/Materials				
1. Date equipment use began (1 pt)				
2. Equipment/material (1 pt)				
3. Program/time (1 pt)				
IV. Standardized Test Data--Changing total dependent upon # tests				
1. Date test given (1 pt/test)				
2. Name of test (1 pt/test)				
3. Score (1 pt/test)				
V. Educational objectives--(56 pts) 2 objectives, ongoing or future, in each domain: socialization, prevocational/vocational; preacademic/academic; communication; self-help/daily living; fine/gross motor; and leisure.				
1. Objective (1 pt/objective)				
2. Domain (1 pt/objective)				
3. Priority level (1 pt/objective)				
4. Current status (1 pt/objective)				
IV. Program implementation: changing total depends on # of ongoing programs				
A. Ongoing programs				
1. Title of program (1 pt/program)				
2. Behavioral objective (1 pt/program)				
3. Definition of response (1 pt/program)				
4. Correction procedure (1 pt/program)				
5. Data procedure (1 pt/program)				
6. Criteria (1 pt/program)				
B. Program monitoring				
1. Program/data review (1 pt/program)				
2. Decision made (1 pt/program)				
3. Reliability of Date & data (1 pt/prog.)				

PROGRAM REVIEW FORM

Student: ______________________________

Program: ______________________________

Step #: ______________________________

Trainer(s): ______________________________

Reinforcer: ______________________________

Date: __________________

Program Summary

	Accelerating	Decelerating	Maintaining
Program Plan:	☐	☐	☐
Program is:	☐	☐	☐

Possible Program Changes: (List at least 3)

1.
2.
3.

Program Decision

Chosen Program Change: # ________

Date Implemented: ______________

☐ Recorded in STEP

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HOW TO FILL OUT THE Program Review Form

Student: Name of the student in the program. If it is a group program, each student should have a separate Program Review.

Program: Name of the program that is being reviewed. If there is a cluster of programs being taught together, each program must be reviewed separately.

Step #: The step that the student is working on at the time that the program is being reviewed, e.g. baseline, Step 1, Step 2.

Trainer(s): The name of the trainer(s) that run the program.

Reinforcer: What reinforcer is being used with the student at the time of this review; e.g. social, hugs, juice, raisens.

Date: The date that the Program Review is filled out.

Program Summary

Program Plan: Describe the goal of the program. For example, is the data supposed to accelerate (increase), decelerate (decrease), or maintain (stay the same)?

Program is: Describe the present trend of the data. For example, is the data accelerating (increasing), decelerating (decreasing), or maintaining (staying the same or bouncing)?

Possible Program Changes

This section needs to be filled out only if there is a discrepancy in the "Program Plan" and the "Program is." If this is the situation, the teacher should list at least three (3) possible modifications that would be approprite to the program, e.g. change reinforcer, change cue.

Program Decision: This section is to be filled out only if program changes are necessary.

Chosen Program Change: The teacher (or team) must decide which one of the 3 Possible Program Changes to implement. Only one should be chosen.

Date Implemented: The actual date that the program change is to be implemented in the classroom.

☐ Recorded in STEP: The Program Monitoring card in the STEP File (or an equivalent) that corresponds to this program should be up-dated. If a program change is to be implemented, this change should be indicated; if no change was necessary, the date of the review should be recorded to indicate that the program was reviewed.

Appendix D

(Module Evaluation Form)

MODULE EVALUATION

(To be completed at the end of the module)

MODULE NAME____ DATE:____________

Rate on the following basis:
1=Bad news 2= Could be better 3= Okay 4= Pretty good 5= Outstanding
If a 1 or 2 rating is given, please note the shortcomings in the space below the subject rated.

1) How well the instructional competancies informed you of the content of the module..1 2 3 4 5

2) How well prepared and organized the module was.........1 2 3 4 5

3) Adequacy of the materials in the module.................1 2 3 4 5

4) Relevancy of the module to current classroom teaching..1 2 3 4 5 NA

5) Relevancy of the module to professional growth (i.e. you may use it in future work)....................................1 2 3 4 5

6) Interest level of the module...........................1 2 3 4 5

7) Fairness and relevancy of the exams...................1 2 3 4 5

8) How well the self-quizes prepared you for the exam.....1 2 3 4 5

9) On a 1-5 scale (1=very easy; 2=easy; 3=just right; 4= difficult; 5=too difficult) rate the difficulty of the content of this module
1 2 3 4 5

10) On a 1-4 scale (1= not enough; 2= enough; 3) more than enough; 4) way too much) rate the amount of information given in the module. 1 2 3 4

11) On a 1-5 scale (1=not at all clear; 2= not quite clear; 3=ok; 4= very clear; 5= outstanding) rate the clarity or the information presented in this module...1 2 3 4 5

12. Name below any articles, books or chapters from this module which you found particularly interesting or helpful.

13. Name below any articles, books or chapters from this module which you feel should be left out or which were particularly unclear, etc. Please tell us why you feel this way.

14. Name any articles, books or chapters which are currently not included in the module which could be added to the module or which you feel presents the material better than the materials in the module.

15. Other comments.

Appendix E

(Abstract of Teacher-Training Study)

ABSTRACT

This study compared the effects of grading contingencies on the practicum assignments of four trainees in a Severely Multiply Handicapped (SMH) teacher-training program. The 21 assignments required for the Advanced Practicum were divided into four blocks and then randomly assigned to two grading strategies. An ABAB reversal design was employed alternating grading strategies across the blocks of assignments. In Strategy A the students received their final grade for the first product they submitted. In Strategy B the students were allowed to re-submit their work until A-level criterion was reached. Feedback from practicum supervisors on each assignment was standardized and revisions were required on all assignments until A-level criterion was reached. The effects of the two grading contingencies will be assessed by examining the first product submitted and the number of revisions required to reach A-level criterion under each strategy.